THE CONTINUUM CONSTRUCTION THEORY: A NEW UNDERSTANDING OF THE CAUSATION AND CONSTRUCTION OF MULTIPLE PERSONALITIES IN PERSONS DIAGNOSED WITH DISSOCIATIVE IDENTITY DISORDER

Rosalind M. Monahan

THE CONTINUUM CONSTRUCTION THEORY: A NEW UNDERSTANDING OF THE CAUSATION AND CONSTRUCTION OF MULTIPLE PERSONALITIES IN PERSONS DIAGNOSED WITH DISSOCIATIVE IDENTITY DISORDER

A dissertation submitted to
The Sanville Institute
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy in Clinical Social Work

By

ROSALIND M. MONAHAN

June 25, 2011

CERTIFICATE OF APPROVAL

I certify that I have read THE CONTINUUM CONSTRUCTION THEORY: A NEW UNDERSTANDING OF THE CAUSATION AND CONSTRUCTION OF MULTIPLE PERSONALITIES IN PERSONS DIAGNOSED WITH DISSOCIATIVE IDENTITY DISORDER by Rosalind Maxine Monahan, and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the Doctor of Philosophy in Clinical Social Work at The Sanville Institute.

Elinor D. Grayer, PhD, Chair — 6/3/11 Date

Alexis Selwood, PhD., Faculty Member — 6/3/11 Date

Kami Bryant, PhD., External Member — 6/15/11 Date

Whitney van Nouhuys, PhD., Dean — 6/24/11 Date

ABSTRACT

THE CONTINUUM CONSTRUCTION THEORY:
A NEW UNDERSTANDING OF THE CAUSATION AND CONSTRUCTION OF MULTIPLE PERSONALITIES IN PERSONS DIAGNOSED WITH DISSOCIATIVE IDENTITY DISORDER

ROSALIND M. MONAHAN

This theoretical dissertation introduces a new way of understanding the evolutionary process in the causation and construction of alter personalities: the *continuum construction theory*. This model explores the intrapsychic world of individuals who create multiple selves or multiple identities that are amnesic for each other as an adaptive mechanism to cope with memories of horrific childhood abuse, and addresses why and how alter personalities are developed.

John Bowlby's object relations attachment theory is linked to contemporary trauma theories that have established childhood maltreatment as an antecedent to the development of alter personalities. In the new *continuum construction theory*, the infant's disorganized attachment pattern to the mother or mother figure has been identified as an even earlier antecedent to the evolutionary process in the formation of alter personalities identified in persons with the most severe forms of dissociation as defined by the *DSM-IV-TR*: dissociative identity disorder (DID) and dissociative identity disorder not otherwise specified (DDNOS). My experience as a practicing therapist and a community mental health administrator for outpatient services and for a psychiatric emergency room

confirms that these disorders do exist and are under-recognized and too often misdiagnosed.

Drawing from Richard Kluft's four-factor theory, I propose a six-stage process that proceeds on a linear continuum beginning at birth, and under certain conditions may begin even earlier, in utero, that leads to the construction of multiple alternative personalities:

1. A disorganized attachment disorder with segregated models of self and mother figure;
2. Childhood maltreatment of a horrific nature, especially childhood sexual abuse;
3. "Selective exclusion" of information – dissociation;
4. Fantasy in the creation of imaginary characters;
5. Introjects in the construction of alter personalities;
6. Dissociative amnesia for the traumatic memories along with blocking of co-consciousness of alters.

The research questions addressed in this dissertation are two: (a) What is the evolutionary process under which various alter personalities are constructed? and (b) What course of treatment would relieve or cure the suffering of individuals who utilize alter personalities as a habitual maladaptive coping strategy throughout their lifespan?

Contemporary theories are used to define stage-oriented, or phase-oriented, treatment strategies currently used in trauma treatment. Finally, the *continuum construction theory* is applied to case material to demonstrate its practical effectiveness.

DEDICATION

IN MEMORY OF

PRISCILLA JANE HAMLIN

1946—2004

It was my sister's deepest wish to be what Winnicott called a "good enough" mother and to provide a secure attachment to her only child. Unfortunately, due to the ravages of a mental illness, she was denied this privilege.

Lorene Louise Knolls

1916—1992

Our devoted mother who made a grand effort in spite of many trials and tribulations to provide a secure attachment to all four of her children.

Max Eugene Knolls

1913—1986

Our strong willed and devoted father who taught me that life was about conquering your demons and then helping less fortunate people, especially those individuals with a disability.

ACKNOWLEDGEMENTS

There are many theoreticians whose bold research and writings have contributed to the conceptualization of this dissertation. However, I wish to specifically honor the work of Pierre Janet, John Bowlby, and Richard Kluft, pioneers in the fields of dissociation, attachment, and dissociative identity disorder (previously multiple personality disorder) respectively, whose research provided the underpinnings for the c*ontinuum construction theory* as presented.

This dissertation would not have been possible without the encouragement, support, help, and love that many people have graced me with throughout the years of development. First, I wish to thank all of the many faculty members at The Sanville Institute who were instrumental in my growth and development over the years and who contributed to my academic achievement. I was blessed to have Donna Sexsmith, PhD, as my mentor during the phase of writing papers. I am grateful to Donna for her patient and caring attitude and for her expertise in correcting grammatical and syntax errors. Donna provided a safe base from which I could explore new theories along with a holding environment to keep me grounded, yet moving forward. I truly enjoyed the many scholarly meetings we had over dinner out or sitting informally in her office or at her kitchen table. I will always treasure her friendship.

I also owe a debt of gratitude to my Dissertation Committee, Elinor Dunn Grayer, PhD, Committee Chairperson, Alexis Selwood, PhD, Second Member, and Kami Bryant, PhD, External Member. Dr. Grayer, "Ellie," was there from the very beginning as the Colloquium facilitator and later as a Second Reader for papers. Ellie has a special way of nurturing students, even following the devastating Northridge earthquake, which

damaged her house and office. What an amazing woman! It was Ellie's simple, but challenging assignment in colloquium, to write a paragraph describing "a self" that planted the seed that eventually led to learning about not one, but many selves or personalities. In the final stretch, it was Ellie who provided invaluable feedback as we sat at her dining room table, a most safe and nurturing environment.

Dr. Selwood, "Alexis," contributed her knowledge and expertise in treating patients with dissociative identity disorder that enriched the writing process. Alexis participated as a Second Reader for a critical paper focused on treating a patient with dissociative identity disorder. I am also grateful to Alexis for suggesting that the dissertation include mention of the "frightened mother" as a contributing factor to the infant's disorganized attachment pattern.

Dr. Bryant, "Kami,' now working in private practice, accepted the responsibility of insuring that this dissertation meet the standards of the professional community. It was my privilege to work with Kami in a mental health clinic where we were often seen as the "radicals" who believed in dissociative identity disorder. I am truly grateful for her support in this research study.

I want to thank the members of the Committee for the Protection of Research Participants, Sylvia Sussman, PhD, and William Dombrowski, PhD. This dissertation would not have gotten off the ground without the oversight and commitment to excellence of Sylvia and Bill. They are to be commended for going above and beyond the call to duty working overtime and in an expeditious manner to insure that all measures were taken to protect the confidentially and to provide for the emotional support of the research Participants.

I also wish to thank and recognize Dean Whitney van Nouhuys for all of the emotional support and administrative interventions that contributed to the culmination of this academic journey. I am most grateful!

I also wish to thank Samoan Barish, PhD past Dean and current facilitator of the Dissertation Proposal Tutorial, for her contribution to this work. It was simply asking questions about which object relations theorists I was interested in that helped hone the ideas linking Bowlby's attachment theory to the construction of alter personalities.

Two other very important individuals that deserve recognition and thanks are Nancy Saks, PhD (in memoriam) and Dianna Simon, PhD. These two dedicated therapists gave freely of their time providing clinical supervision at the doctoral level.

I would be remiss not to thank the pillars of support at the Sanville Institute, (previously the California Institute for Clinical Social Work) both Molly Mitchell, who worked in the office when I entered the program, and Tina Casenza who followed in Molly's footsteps. Molly, and then, Tina's routine daily administrative duties over the years included, making plane and hotel reservations, coordinating ground transportation, preparing lunch at convocations, and other important nurturing activities in the service of faculty and students. I especially want to thank Angeleen Campra, PhD. In addition to working in the Institute office, Angeleen was the editor of this work. Angeleen's cogent and incisive editorial comments on several drafts, as well as her expertise in APA guidelines brought the work to the finish line. However, I also want to thank Angeleen for her patience and emotional support that were invaluable to me. I am deeply thankful to the entire Institute faculty whose names were not mentioned.

And finally, I wish to thank Jean Sanville, PhD for supporting the Sanville/Smith collaborative. Through Dr. Sanville's generosity students from both schools were provided with an opportunity to be exchange students and experience new and different learning experiences. These are memories that I will forever cherish.

I wish to give my deepest heartfelt thanks to all of my family members who have been patiently waiting—for a very long time— for me to earn a PhD. The person who deserves my most sincere thanks is my husband, friend, and soul mate, Hank, who made it possible by believing in my abilities and never letting me give up. Over the course of this journey, Hank's generosity in supplying an abundance of emotional and financial support never waivered. I am also grateful for the understanding and patience of my daughter, Sheri, who grew up, married, and had two children while waiting for me to finish school. Matt and Nicole, my West coast grandchildren, have spent their entire lifetime knowing me as "Tutu" the student. I also appreciate the encouragement from my other daughters, Kathy, Tara, and Megan and my East coast grandchildren, Anna, Katie, Emily, Melissa, Allie, Olivia, and Kevin. It is my sincere wish that my academic achievement would be an inspiration for all of my grandchildren to never give up on their career endeavors and to be all that they can be. I also wish to thank my sister, Pat, who has been a most patient and enthusiastic cheerleader. Her encouragement over the years has meant a great deal to me.

Finally, and most especially, I would like to thank the Participants who graciously allowed me the privilege of sharing information from their case files to illustrate the causation and construction of multiple alternative personalities. They are the heart and soul of this work.

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION

Statement of the Problem

A strong and growing body of contemporary research now indicates there is a causal connection between a history of maltreatment in childhood and dissociative pathology in adult life (Steinberg, 1995, p. 5). Ian Hacking (1995), a contemporary philosopher and scholar of dissociative identity disorder (DID), which was previously called multiple personality disorder (MPD), states, "Without a severe and repeated childhood trauma, typically of a sexual sort, multiple personality is not likely to appear" (p. 82). Of the dissociative disorders identified in the *Diagnostic and Statistical Manual of Mental Disorders IV-TR* (American Psychiatric Association, 2000b) Dissociative Identity Disorder (DID), previously known as (MPD), and Dissociative Identity Disorder Not Otherwise Specified (DDNOS) have now been linked to the most severe negative outcomes of childhood maltreatment, especially childhood sexual abuse (CSA) (Wolfe, 2007, pp. 686-687).

Additionally, attachment research has revealed that an insecure disorganized/disoriented attachment to the primary mother figure is also relevant to the development of dissociation. Research in the area of neurobiology and dissociation has increased our understanding of the functioning of the hypothalamic-pitutary-adrenal (HPA) stress axis with particular attention to the secretion of cortisol, the hormone related to stress (Schore, 2009, p. 113; Wieland, 2011, p. 12). This promising research reveals that cortisol levels may be linked to the inability of individuals to block out intrusive thoughts under stress or increase blocking out what is happening, leading to dissociation.

Looking back at the history and evolution of the diagnosis of DID reveals controversy and differing opinions. In 1989 Richard Loewenstein, M.D. the president of the International Society for the Study of Multiple Personality & Dissociation (ISSP&D), now known as the International Society for the Study of Trauma and Dissociation (ISSTD), as paraphrased by Greaves (1993), proclaimed, "Never in the history of psychiatry have we ever come to know so well the specific etiology of a major illness, its natural course, its treatment" (p. 371). In both past and recent times the existing theory supporting the extreme level of dissociation that leads to the creation of alter personalities is Kluft's (1984) four-factor theory, to be discussed below. Yet, despite this proclamation and the growing body of literature regarding the theories of dissociation, in 2009 van der Hart and Dorhay wrote "there is little agreement about (a) the definition or meaning of dissociation, and (b) the specific psychological phenomena to which the construct refers" (p. 4). There is also debate on whether "dissociation is best understood as a continuum that ranges from the normal to the pathological" (p. 4). They further stated, "We contend that the dissociation field is in need of some conceptual housecleaning . . . Terms must be clarified . . . It would probably be helpful to decide which terms are to be preferred" (p. 21).

There also remains a high degree of controversy in the professional community regarding whether these disorders exist. Some authors support an iatrogenic effect; meaning that the alter personalities are caused by the clinician, while other authors completely discount the diagnosis. However, it is the position taken in this dissertation that the disorders of DID and DDNOS do exist and are under-recognized and misdiagnosed. It is a significant problem that patients are spending an average of eight or

more years in treatment before they are accurately diagnosed with DID or DDNOS and benefiting from appropriate treatment.

In order to accurately assess, diagnose, and plan effective treatment to the increasing number of patients who have DID or DDNOS, along with other comorbid psychiatric disorders, it would benefit clinicians to become familiar with the theories of the etiology of dissociation. It is important to understand the developmental link between the patient's history of childhood environmental traumata and the dissociated symptoms, which contemporary theorists consider to be posttraumatic in origin (Fine, 1990; Kluft, 1985b; Schore, 2009; Spiegel, 1991) To enrich this discourse, a historical overview of how trauma is defined in the early psychoanalytic literature, including the classical psychoanalytic perspective, the ego psychological perspective, and the object relations perspective will be provided.

Furthermore, the clinician needs to understand how, without effective interventions, dissociation, and eventually "vertical splitting" (Hilgard, 1977, P. 80) as opposed to "horizontal splitting" or repression becomes a defensive coping style that may be used throughout the patient's lifespan. In order to grasp the theory that dissociative disorders, especially the diagnoses of DID and DDNOS, are no longer considered rare disorders and are linked to childhood maltreatment, clinicians need to appreciate the statistical prevalence of childhood maltreatment in contemporary society (Steinberg, 1995, p. 4). Finally, I believe that Kluft's (1984) four-factor theory needs to be revised to incorporate contemporary research. I propose a new six-factor theory, the *continuum construction theory*, to bring attention to the antecedents that mark the evolutionary trajectory leading to the construction of multiple alternative personalities. I posit that the

trajectory takes root in the formation of a disorganized/disoriented attachment pattern in the infant/mother figure dyadic relationship.

Purpose of the Dissertation

The purpose of this dissertation is to contribute a new theory with a broad perspective to the growing body of complex posttraumatic stress literature and further the understanding of the causation and construction of multiple personalities or alternative personalities in patients diagnosed with DID or with DDNOS. While there is no single way to understand the etiology of DID or DDNOS, I provide an overview linking the early history of hysteria, later called dissociation, and early psychoanalytic theories to neo-dissociation theories. I also reintroduce the concept of fantasy that was first presented by Freud and later by Klein and demonstrate how a child's normal imaginary behavior or non-pathological behavior is used in the service of wish fulfillment or wishful mastery over severe environmental trauma. I then provide research bridging John Bowlby's attachment theory to contemporary theories, including theories of neurobiology and dissociation and how they are related to the development of DDNOS and DID. The contemporary theories also define stage-oriented or phase-oriented treatment strategies, which are largely considered the *sine qua non* for trauma treatment.

I begin by providing an in-depth look at childhood maltreatment with a particular interest in childhood sexual abuse. However, it should be noted that the "methodologically sound" empirical research linking childhood sexual abuse to DID is still small, "as is the quantity of prospective treatment outcome data" (Ross, 1997, p. 127). I discuss how to assess and diagnosis patients with complex trauma symptoms with a primary focus on the utilization of Marlene Steinberg's (1994b) Structured Clinical

Interview for DSM-IV (SCID-D-Revised). The SCID-D-Revised has been tested for reliability and validity when diagnosing DID and DDNOS and was utilized in the case material presented in this current study. I also briefly mention other interview tools that are discussed in the literature.

Additionally, I discuss Bowlby's attachment theory, with a focus on the disorganized/disoriented attachment pattern (Solomon & George, 1999) and various contemporary trauma theories with stage-oriented treatment modalities. These modalities are recommended for treating patients who have the complex dissociative disorders of DDNOS and DID. The stage-oriented models that are discussed include Ross's (2000) Trauma Treatment; van der Hart, Nijenhuis, and Steele's (2006) Structural Dissociation; Ogden, Minton, and Pain's (2006) Sensorimotor Psychotherapy; Twombly's (2000) adapted version of Eye Movement and Desensitization and Reprocessing (EMDR); the controversial use of hypnosis (Kluft, 1995; Sapp, 2000); and Lemke's (2007) guided imagery as a adjunct to hypnosis. Illustrations of case material are provided..

Delimitations

It is not the intent of this dissertation to prove whether DID is a real disorder or not. Just as there were skeptics that questioned the reality of hysteria in Janet's time and questioned the reality of multiple personalities in the 1980s – those nonbelievers who labeled advocates of the disorder as "radicals,"— I acknowledge that there remain skeptics today. I take the position of the radical; it is real.

Nor does this dissertation consider the dissociation related to neuroanatomical injury, organic disorders or temporal lobe epilepsy and delirium as a contributing factor

to the causation of multiple personalities. This type of dissociation is considered functional dissociation in the psychoanalytic literature (Liotti, 1999a, p. 311).

Research Questions

There are two research questions addressed in this dissertation: (a) What is the evolutionary process under which various alter personalities are constructed? and (b) What course of treatment would relieve or cure the suffering of individuals who utilize alter personalities as a habitual maladaptive coping strategy throughout their lifespan?

Why do we need to know the causation of multiple personalities or how alters are constructed? Because patients want to know what is making them ill. When a patient can put a name to their suffering and know there is treatment and the possibility of a cure (Kluft, 1984), it gives them hope. Clinicians need to understand the causation of an illness to design effective treatment modalities. Knowledge also helps to educate society, prevent disorders from occurring, and alleviate human suffering. As one patient put it, " I know that I am crazy. I have struggled all of my life with this craziness. But now that I have a name for it, I can better deal with it."

Six Stages on the Continuum

In this theoretical dissertation, I propose a six-stage process that proceeds on a linear continuum beginning at birth and leading to the causation and formation of alter personalities identified in persons with the most severe forms of dissociation, i.e., those that meet the criteria as outlined in the *DSM-IV-TR* (American Psychiatric Association, 2000a) for the diagnostic category of DID or DDNOS (Silberg & Dallam, 2009, p. 69). It is possible that under certain conditions the process may begin even earlier, in utero. The six stages on the continuum of the construction of alter personalities are

1. A disorganized attachment disorder with segregated models of self and mother figure;
2. Childhood maltreatment of a horrific nature, especially childhood sexual abuse;
3. "Selective exclusion" of information – dissociation;
4. Fantasy in the creation of imaginary characters;
5. Introjects in the construction of alter personalities; and
6. Dissociative amnesia for the traumatic memories along with blocking of co-consciousness of alters.

Disorganized/Disoriented Attachment Disorder

An insecure attachment in the dyadic interactive process between an infant and a mother or mother figure was first discussed by John Bowlby (1969/1982, 1973, 1980, 1984, 1988). Later research identified that the development of a disorganized/disoriented attachment pattern (a "D" attachment pattern) formed in the dyadic interactive process between infant and mother or a substitute mother figure may begin at birth (Liotti (1999a, p. 291; see also Main 1999, 2002). It is at the moment when the umbilical cord is cut and the infant is placed in the mother's arms, or for various reasons is separated from the birth mother, that the infant *begins* the attachment process. If conditions are less than ideal, and the mother figure is unable to meet the infant's demands for nurturing and attunement, an attachment disorder is a likely outcome. The disordered attachment process will initiate the construction of "multiple segregated or dissociated models of the self and the mother figure" (Liotti, 1999a, p. 291). These are also referred to by Bowlby (1988) as multiple internal "working models" (p. 144) of the self and mother figure in attachment theory. An attachment disorder is, therefore, considered to be an antecedent

in the etiology of the range of dissociative disorders. Expanding on this concept, I argue that a "D" attachment pattern or disorder may also be considered an antecedent first step leading to the causation and construction of alter personalities when certain conditions are met. This argument is discussed below.

Building upon the concept of a "D" attachment pattern and multiple internal working models of self and the mother figure, I am proposing a new perspective, hence forth called the "*continuum construction theory,*" for understanding the causation and construction of alter personalities. This theory is not to be confused with or take away from Putnam's "continuum model" for measuring dissociative phenomena. Putnam (1989) writes, "central to the concept of the adaptive function(s) of dissociation is the idea that dissociative phenomena exist on a continuum" (p. 9). Putnam cites two sources of evidence for his theory. In his first line of reasoning, he points out that there is a continuum of hypnotizability scores in the general population ranging from highly resistant to easily hypnotized. It has been established in the literature that people who dissociate are highly susceptibility to hypnotism (Braun & Sachs, 1985). "A second line of evidence supporting the concept of a continuum of dissociative experiences . . . comes from surveys using the Dissociative Experience Scale" (Putnam, 1989, pp. 9-10), the first objective measure of dissociative experiences.

Childhood Maltreatment of a Horrific Nature

It is believed that child abuse of a horrific nature is related to the formation of alter personalities. The relationship between environmental trauma and dissociation, which I contend precedes the formation of alters, has been asserted by a large body of literature discussing posttraumatic stress disorders (e.g., Ford, 1999, 2009; Friedman,

Resick, & Keane, 2007; Pain, Bluhm, & Lanius, 2009) the dissociative disorders, (e.g., Baita, 2011; Barlow & Freyd, 2009; Beere, 2009; Braude, 2009; Braun, 1988; Bremner, 2009; E. A. Carlson, Tuppett, Yates, & Sroufe, 2009; Cardena & Spiegel, 1996; Chu, 1998; Gold & Seibel, 2009; Liotti, 2009; Schore, 2009; Solomon & George, 1999; Steele, van der Hart, & Nijenhuis, 2005, 2009; van der Hart & Dorhay, 2009; Wieland, 2011), the borderline disorders (e.g., Zanarini & Jager-Hyman, 2009), and the anxiety disorders (e.g., Bryant, Moulds, & Nixon, 2002; Cox, Clark, & Enns 2002). However, I agree with Liotti (1999a) that it would be "erroneous . . . to regard dissociation as a necessary consequence of psychological trauma, or traumatic events as a necessary antecedent of the dissociative process" (p. 312).

As a next step in the formation of alter personalities, I assert that when the infant or young child with a "D" attachment pattern to the mother figure experiences enduring childhood maltreatment of a horrific nature, the child will dissociate as an adaptive response to overwhelming affects prior to developing alter personalities. Child abuse of a horrific nature is described as consisting of severe neglect, physical abuse, and most especially childhood sexual abuse (Freyd, 1994; Freyd, Klest, & Allard, 2005). Abuse perpetrated by a parent or trusting caregiver has been defined by Freyd (1994) as "betrayal trauma." Furthermore, when a child is a victim of betrayal trauma s/he has experienced an inconsistency in parenting. Sometimes the parent is safe and provides comfort while at other times the same parent is abusive. When there is no other trusting person to turn to who will mitigate the abuse, the child will utilize their normal, non-pathological ability to fantasize and create imaginary playmates or other characters to self-sooth.

Selective Exclusion/Dissociation

Next in the sequence of steps proposed utilizing Bowlby's (1980) concept of "selective exclusion" borrowed from human information processing theory, I suggest that the abused child will utilize selective exclusion as an adaptive response to block out or to dissociate certain types of memories from consciousness. Bowlby posits that there is much evidence to support the theory that human information processing is also "conceived of as a 'multi-stage process'" (p. 54). During the sequence of stages certain information may be excluded before it reaches a final stage of consciousness. The basic concept proposed by Bowlby is that certain types of information that may have already been stored in long-term memory are being excluded or blocked from further processing. In the case where some of this information is already stored in long-term memory, defensive exclusion results in some degree of amnesia. In the case where new information is arriving via the sense organs, defensive exclusion results in some degree of perceptual blocking (Bowlby, p. 54).

Furthermore, according to Bowlby (1980), consciousness can be regarded as a state of mental structures that facilitate certain distinctive types of processing. Among them are the ordering, categorizing and encoding of information; the retrieving of information; reflective thought that allows making long-term plans and high level decisions; and the inspection of certain overlearned and automated action systems that may be maladaptive and need revision or correction. Bowlby further contends that two basic structures of one's conscious mind are "(a) that which mediates attachment behavior and (b) that which applies all those rules for appraising action, thought and feeling that together are usually referred to as constituting the super-ego . . . and are

conceived of as being stored in long-term memory" (p. 54). Within attachment theory, there is general acceptance of the following statement from Bowlby:

> Representational models that a person builds of his attachment figures and also the form in which his attachment behavior becomes organized are regarded as being the results of learning experiences that start in the first year of life and are repeated almost daily throughout childhood and adolescence. (p. 55)

Furthermore, when the cognitive and the action components in the attachment system are combined with the super-ego's rules for appraising action, thought, and feelings, and are overlearned, they become engrained and operate automatically and out of conscious awareness. The disadvantage to this arrangement is that the action components and the super-ego's appraising rules are less readily accessible to conscious processing and, therefore, are difficult to change. "In some instances, the rules implemented by the evaluative system forbid its being reviewed" (Bowlby, 1980, p. 55), especially when secrets of sexual abuse are involved. In some cases the child has been threatened that harm will come to a relative or pet if they violate the rule and reveal the secret. Furthermore, violating this rule might lead to yet another stage of defensive exclusion. Bowlby cautions, "the individual subjected to defensive exclusion for prolonged periods has far-reaching consequences" (p. 64). There are two main consequences that Bowlby brings to our attention:

> (a) One or more behavioural [*sic*] systems within a person may be deactivated, partially or completely. When that occurs one or more other activities may come to monopolize the person's time and attention, acting apparently as diversions. (b) One or a set of responses a person is making may become disconnected

> cognitively from the interpersonal situation that is eliciting it, leaving him unaware of why he is responding as he is. When that occurs the person may do one or more of several things, each of which is likely to divert his attention away from whoever, or whatever, may be responsible for his reactions:
>
> He may mistakenly identify some other person (or situation) as one who (which) is eliciting his responses.
>
> He may divert his response away from someone who is in some degree responsible for arousing them and towards some irrelevant figure, including himself.
>
> He may dwell so insistently on the details of his own reactions and sufferings that he has no time to consider what the interpersonal situation responsible for his reactions may really be. (p. 65)

In summary, the person's behavioral system is considered by Bowlby (1980) to be "deactivated" and significant information is "repressed" (p. 65). However, there are times when fragments of the information seep through into conscious awareness causing emotional pain. Bowlby suggests that the conditions that promote defensive exclusions include the nature of the information. Drawing from Peterfreund's 1971 information theory, Bowlby further asserts that the information likely to be defensively excluded is such that it has caused severe suffering to the person. Other possible reasons to consider are that when incoming information is evaluated by the self's own evaluating system, it may arouse feelings of guilt and conflict; the information might result in serious conflict with parents; the child's attachment behavior is not responded to and terminated; lastly, and perhaps most significant for this discussion, is that the child's attachment behavior is

rejected, and the child is punished or threatened with punishment for crying for help. Bowlby states, "Like repression, defensive exclusion is regarded as being at the heart of psychopathology" (p. 65).

The Role of Fantasy in the Construction of Alter Personalities

In the *continuum construction theory*, I discuss the concept of fantasy in the construction of alter personalities. In contrast, early psychoanalytic theories of Freud and later of Klein postulated that the infant's fantasy was intrapsychic and related to internal drives (Fonagy, 1999). I argue that the child's normal imaginary behavior or non-pathological behavior is used in the service of wish fulfillment or wishful mastery over severe environmental trauma.

Young (1988b) asserts that "fantasy itself has a major role in determining the symptom picture seen in multiple personality disorder" (p. 34). He further states that "many of the characteristics of alter personalities reflect elaborate fantasies of restitution in children who have suffered severe traumatization" (p. 34). Young (1988a) acknowledges the earlier works of Beres and also Lichtenberg and Pao as he defines fantasy as "the child's imaginary unfolding of imagery and ideas used in the service of wish fulfillment or wishful mastery over a severe [traumatic] environment" (p. 14). Young tells us that in Freud's initial theory, hysteria was viewed as a traumatic neurosis that could only be resolved when the traumatic event(s) was made conscious. Later, Freud changed his view and proposed "the idea that unconscious fantasy and wish-fulfillment were at the root of symptom formation" (p. 13). In other words, according to Freud's revised theory, in reality a traumatic event never happened. Young quotes Freud in referring to the "vanished mental life of children" as follows:

> Unconscious fantasies are the immediate psychical precursors of a whole number of hysterical symptoms based on fantasy. . . . Unconscious fantasies have either been formed in the unconscious; or – as is more often the case – they were once conscious fantasies, or daydreams, and have since been purposely forgotten and have become unconscious through "repression." (p. 13)

Young (1988a) quotes Freud in a later work as stating, "Hysterical symptoms are not attached to actual memories, but to phantasies erected on the basis of memories" (p. 13). Freud again shifted his view when addressing the problem of dissociative symptoms in *Beyond the Pleasure Principle* (1920/1955). Here, according to Young, Freud describes the concept "'compulsion to repeat' unresolved trauma" (p.13), which is a real life event, as an attempt to master psychic trauma. I am in agreement with Young who posits:

> Much of the clinical phenomena in multiple personality disorder [DID] arises [*sic*] when fantasies of restitution are repressed and defensively incorporated into dissociative states. The memory of the fantasy is forgotten as the fantasy becomes dissociated. While fantasies play a part in the disorder, they are efforts . . . to master real trauma. (p. 14)

Fantasy, then, becomes incorporated into the formation of the alter personalities. Indeed, these fantasies may be based on imaginary playmates or other imaginary characters. A report by Pines (1978) reveals that "up to 65 % of normal children have invisible companions" (p. 142). In addition, Young (1988a) relays a case described by Kluft in which a child client was partially aware of a dissociated alter personality whom he called Marvin. The alter personality or Marvin not only represented the character Captain Kirk from the Star Trek television series (Roddenberry, 1966-1969), but

interestingly, Marvin also represented the child's real life father. Young presents this as an example of how fantasies in the service of mastering trauma evolve into "dissociated mental structures" (p. 15).

Another study by Bliss (1984) found that 8 percent of alter personalities "represented early imaginary playmates" (p. 142). According to Bliss, "the process begins with realistic imaginary companions who are consciously known" (p. 139). Bliss contends that it is "at the point of developing partial or complete amnesia" (p. 139) that one can say that a multiple personality begins to form. Bliss further notes that multiple personality states are "obviously imaginary constructs" (p. 140). A more in-depth discussion on amnesia will be provided below.

S. Wilson and Barber (1983) studied a group of normal subjects with fantasy prone personalities. Young (1988a), drawing from S. Wilson and Barber, asserts that this subgroup is characterized by reliving their memories in all sensory modalities, including somatic memories and "numerous dissociations and out-of-body experiences" (p. 15). It is noteworthy that this fantasy prone group comprises 4 percent of the overall population, which is the same percentage of the population that is considered to be highly hypnotizable. While multiple personalities are not a fantasy, as in an imaginary playmate, I am in agreement with Young that fantasy plays a key role in the formation of multiple personalities, or said differently, in the construction of alter personalities.

Young (1988a) further postulates, "Fantasies of restitution are repressed and defensively incorporated into dissociative states . . . [or] psychological substrate[s] upon which alter personalities form" (p. 14). Here the reader is left to wonder if Young is suggesting the formation of fantasies of revenge, which may come later with the

introjection of real perpetrators. Young explains that the prior fantasy is transformed into "a defensive structure with relative autonomy" (p. 17), a process he calls "the structuralization of fantasy," (p. 17). According to Young, the process of constructing an alter personality will incorporate the memory of the event with its affects, sensorimotor components, distortions, and associations.

In support of Young's theory other authors including Braun (1984), Braun and Sachs (1985); Bliss (1980, 1984); Fagan and McMahon (1984); Kluft (1984, 1985a, 1985b) have all described the construction of alter personalities as an evolutionary process rather than an instantaneous one, also known as "the big bang theory" (Young, 1988a, p. 15). Young, drawing from the work of Braun (1984); Kluft (1985b), and Bliss (1984), provides additional evidence for the evolutionary theory when he states, "early personalities in children initially seem not to be persecutory and aggressive, but develop new characteristics with the passage of time, suggesting that even unconscious fantasy can evolve significantly" (p. 17).

It must be clarified that while a child experiencing a trauma may instantaneously dissociate or enter a state of withdrawal, the trauma by itself does not produce an alter personality as suggested in the "big bang theory." Young (1988a) contends:

> Repeated entry into states of withdrawal provides a substrate in which a fantasized system can become organized into a more permanent structure . . . separated by amnesic boundaries. . . . [Eventually], these evolving states of dissociation become increasingly structuralized by the assimilation of either fantasy elaboration, identifications with real or imagined people in the child's life, or, more likely a combination of both. The fantasies begin as conscious attempts

at mastery and gradually become internalized into fixed mental structures that function increasingly independently. (p. 17)

In contrast, there are children who enter a state of dissociation who do not develop multiple personalities (Fraiberg, 1982). Emde (1971) observed infants who were being circumcised enter a state of withdrawal following the circumcision. Thus, dissociation appears to be a process that occurs independently but may be followed by the incorporation of fantasy and the subsequent development of alters (Young, 1988a, p. 17). Bliss (1986) further contends that in order to develop multiple personalities or alters, the individual must have the "capacity for dissociation and hysterical symptomology" (p. 66), and according to Young, they must also "enter a state of self-hypnosis (p. 17). Bliss concludes that multiple personality disorder [DID] "begins in childhood, usually [as] a defense against physical, sexual, or psychological abuse . . . [where] the prime mechanism appears to be spontaneous self-hypnosis, which creates amnesias, an unconscious repository, personalities, and many other symptoms" (p. 162). Young tells us that this theory is in line with Breuer (Breuer & Freud, 1895/1955) who contends that the mechanism for hysteria was a "hypnoid state" (p. 17).

In summary, according to Young's (1988a) structuralization of fantasy theory, the construction of alter personalities evolves in a stepwise process beginning with a traumatic act of child abuse. As a defense against the trauma, the child withdraws into a spontaneous hypnoid-state or dissociated state. Repeated entry into states of withdrawal provides a substrate in which a fantasized system can become organized into a more permanent structure separated by amnesic boundaries. With repeated acts of abuse, the child may wish for imaginary playmates or other imaginary characters to help gain

mastery over a severe and overwhelming traumatic situation. Over time, the fantasy may include identifications with real or imagined people in the child's life, or, more likely a combination of both. While the fantasies begin as conscious attempts at mastery, they gradually become internalized into fixed mental structures or alter personalities that function increasingly independently. Similar to Freud's initial theory that hysteria was a traumatic neurosis that could only be resolved when the traumatic event(s) was made conscious. Young contends that this complex structuralization of fantasy will be rendered unavailable for integration until such time as it is brought to consciousness and can be relinquished.

The Role of Introjects in the Construction of Alter Personalities

Moving along the continuum, the child may eventually create alter personalities to gain mastery over the environmental trauma of abuse. Many types of alters have been described in the literature and by my patients. I contend that the construction of alter personalities entails a molding of internalized aspects of the self and other, which could represent the perpetrator(s) as well as other significant persons in the child's life (Fonagy, Gergely, Jurist, & Target, 2002). Some are child alters that hold secrets of the abuse, often stored in body memories.

That being said, I disagree with the "big bang" theory as written about by Young (1988a, p. 15), but not necessarily supported by him, suggesting that alter personalities are formed at the moment of a traumatic event(s).

Dissociative Amnesia for Traumatic Memories and Blocking of Co-Consciousness

Following years of debate, the DSM-IV Work Group added an amnesia criterion to the diagnosis of DID: "C. Inability to recall important personal information that is too

extensive to be explained by ordinary forgetfulness" (American Psychiatric Association,1994. p. 487). However, there is still a great deal of ongoing debate regarding the diagnostic differences between DID and DDNOS (Dell & O'Neil, 2009). Currently, the *DSM-IV-TR* (American Psychiatric Association, 2000a, p. 242) diagnostic criterion for DDNOS does not require the presence of amnesia. For purposes of this research, I am limiting our discussion to that of *dissociative amnesia.*

E. A. Carlson, Tuppett, Yates, and Sroufe (2009) posit that across the developmental spectrum, dissociative process may manifest in disturbances with many symptoms, including memory dysfunction (p. 39). Van der Hart et al., (2006) quote Freyd as stating, "Some evidence suggests that dissociative amnesia is particularly characteristic of survivors of chronic childhood abuse and neglect and perhaps abuse by close relatives and caretakers" (p. 54). Furthermore, E. A. Carlson et al. (2009) drawing from the work of Liotti (1992, 1999a) assert, "attachment disorganization may be a mechanism by which traumatic experience in the caregiving environment is translated into adaptational vulnerabilities such as dissociation" (pp. 44-45).

Van der Hart et al., (2006) state:

> Dissociative amnesia occurs in varying degrees. For example, the individual may be unable to recall certain parts of memory, or may know what happened, but not recall the episode with a sense of personal ownership ("It happened, but not to *me"*). (p. 93)

The DSM-IV-TR (2000b) classifies five types of dissociative amnesia, including localized, selective, systematized, generalized, and continuous.

1. In *localized amnesia* the patient fails to recall events during a circumscribed period of time. The amount of time can range from minutes, hours, or days following a traumatic event. But it is always for a short duration following a profoundly disturbing event. For example, when a 13 year-old girl is raped, she may not remember how she got away form the perpetrator, how she got home, etc., but she may remember most of the rape (van der Hart et al., 2006, p. 93). As an adult, the patient may get triggered by someone reminding her of the perpetrator and dissociate, losing hours of unaccountable time.
2. In *selective amnesia*, the patient can recall some, but not all of the events during the circumscribed period of time. A survivor of abuse may remember that they were sexually abused by an uncle, but may not recall that their pet was killed to threaten her (p. 93).
3. *Systematized amnesia* is a loss of memory for certain categories of information. For example, one patient might not remember anything about the 3rd grade, but recalls the school, friends and teachers.
4. *Generalized and continuous amnesia* are both considered very rare. In *generalized amnesia* the person is unable to recall their entire life. In *continuous amnesia* the person is "unable to recall all events subsequent to a specific time up to and including the present. . . . Some patients with dissociative amnesia may be unaware of their amnesia and have so-called 'amnesia for amnesia'" (van der Hart et al., 2006, pp. 93-94). Many patients realize only in retrospect the serious degree of their amnesia.

In summary, "dissociation is a complex psychophysiological process that alters the accessibility of memory and knowledge, integrating behavior and sense of self" (E. A. Carlson et al., 2009, p. 39). When a person experiences localized or selective amnesia, identity and selfhood, the fundamental problems of personality, are disrupted (Alpher, 1996, p. 1238).

Furthermore, Guntrip (1971) notes "identity is the biggest single issue that can be raised about human existence" (p. 119). A person with DID is experiencing a major disruption of identity and selfhood.

In conclusion, it has been well documented as far back as Janet and Freud's time that the etiological role of traumatic experiences and the dissociative processes leads to disturbances in memory and selfhood. In comparison, less attention has been paid to the developmental processes between trauma and dissociation that result in disturbances of the self (E. A. Carlson et al., 2009, p. 39). The object relational model of attachment stresses "long enduring effects of early maternal infant relations and posits that the critical period for personality formation occurs from birth to three years" (Schore, 1994, p. 25).

It is the intent of this theoretical dissertation to revise Kluft's (1984) prevailing four-factor theory with a six-state theory that identifies the evolutionary trajectory under which various alter personalities are constructed. The convergence of early psychoanalytic theories, especially Bowlby's attachment theory, contemporary theories of trauma, body oriented psychotherapies, and the neurobiology of dissociation informs the new *continuum construction theory* as it relates to the causation and construction of multiple personalities in dissociative identity disorder.

Chapter One has identified the problem to be studied, the research questions, the methodology utilized and the new proposed six-stage theory, *the continuum construction theory,* as a revision to Kluft's (1984) four-factor theory This theory identifies the trajectory leading to the formation of multiple alternative personalities in persons diagnosed with DID and DDNOS. The next chapter will examine the prevalence of abuse and neglect that many children endure and its long-term consequences.

CHAPTER TWO: CHILDHOOD MALTREATMENT

It has been a long-held belief that childhood maltreatment is a contributing factor to the development of dissociative disorders. In fact, contemporary theories of dissociation "suggest that a combined influence of experience (i.e., repeated trauma) and biological reorganization as a function of experience contribute to pathological dissociation" (E. A. Carlson et al., 2009, p. 40). In the *continuum construction theory* proposed by this writer, childhood maltreatment of a horrific nature is considered a required antecedent in the evolutionary process of the construction of alter personalities and the diagnosis of dissociative identity disorder (DID) and dissociative identity disorder not otherwise specified (DDNOS). Further, since current research has demonstrated that both DID and DDNOS are not rare disorders, it is vital that clinicians grasp the severity of the prevalence of childhood maltreatment and assess for dissociative disorders.

Crooks and Wolfe (2007) state:

> At its most basic level, "child maltreatment" is a generic term describing volitional or neglectful acts on the part of a child's caregiver that result in, or have the potential to result in, physical injuries and/or psychological harm. Maltreatment includes . . . (1) neglect (failure to provide care in accordance with expected societal standards for food, shelter, clothing, protection, and affection); (2) emotional abuse (verbal abuse, isolation, exposing children to violence); (3) physical abuse (non-accidental bodily injury); and (4) sexual abuse (sexual contact, including attempts or threats). (p. 640)

Maltreatment has also been identified by a variety of researchers, and numerous correlational studies have confirmed a high incidence of childhood trauma – sexual, physical, and probably emotional abuse – in both adults and children with dissociative disorders (e.g., Allen, 2001; Baita, 2011; Braun & Sachs, 1985; Briere, 1992; E. A. Carlson, Cicchetti, Barnett, & Braunwald, 1989; Courtois, 1999; Crooks & Wolfe, 2007; Davies & Frawley, 1994; Edwards, Anda, Shanta, Maxia, Dong, Chapman, & Felitti, 2005; Fine, 1991; Goodwin, 1985; Green, 1996; Freyd, 1994; Herman, 1992; Kahn, 2006).

Statistical Prevalence of Childhood Maltreatment

In 1996, the United States Department of Health and Human Services (USDHHS) amended The Child Abuse, Prevention and Treatment Act (P.L. 93-247), which resulted in the establishment of the National Child Abuse and Neglect Data System (NACANDS). The purpose of NACANDS was to annually collect and analyze data from all state child protective agencies that were relevant to abuse and neglect and submit this report back to the USDHHS (Rodriguez-Srednicki & Twaite, 2006, p. 5).

Crooks and Wolfe (2007) use statistics from the 2005 report of the USDHHS as a source for data on childhood maltreatment in the United States. According to Crooks and Wolfe:

> Every week, more than 50,000 children are reported as victims of suspected child abuse and neglect in the United States alone. . . . This weekly toll translates into an annual rate of about 3 million reports per year . . . [with] about one-third of these reports being substantiated cases with child protective services. . . . Child neglect (including medical neglect) continues to be the most common form of

> maltreatment, accounting for close to 60% of all *documented* [italics added] cases in the United States. Almost one-fifth of the children suffered physical abuse, and nearly 10% were sexually abused. In addition, about one-fourth of these children suffered more than one type of maltreatment. (p. 641)

Crooks and Wolfe (2007) further inform us that physical abuse victims are usually younger children who need the most care and supervision, while toddlers, preschoolers, and young adolescents are the most common victims of a combination of both physical and emotional abuse, which, according to Crooks and Wolfe, corresponds with the push for greater independence during various developmental periods (p. 642). In contrast to physical and emotional abuse, "Sexual abuse is relatively constant from [age] three on" (p. 642).

Further, Goldman (2010) states:

> Child abuse is a hidden epidemic . . . [and] a report of child abuse is made every ten seconds. In Montgomery County (outside of Washington DC) in 2007 . . . officials documented 599 cases. And we know that when the economy gets worse, violence towards women and children goes up exponentially . . . and abused children may "fly under the radar." (p. 13)

A more recent NACANDS report on child abuse, the Fourth National Incidence Study of Child Abuse and Neglect (NIS-4), for the study period 2004-2006, was released January 28, 2010. According to this study, the NIS-4 applies two parallel standards to define child abuse: the Harm Standard, and the Endangerment Standard. The Harm Standard measurement, which is thought to be very "stringent" with a narrow perspective of abuse, found that "more than 1.25 million children (an estimated 1,256,600 children)

experienced maltreatment. . . . This corresponds to one child in every 58 in the United States" (Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, & Li, 2010, p. 5). The Endangerment Standard measurement, a "more inclusive" measurement, estimated that "nearly 2,905,800 children had experienced child abuse and neglect. . . . This corresponds to one child in every 25 in the United States" (p. 6).

It is important to keep in mind when conducting analyses with NCANDS data that state-to-state variation in child maltreatment laws and information systems may affect the interpretation of the data. Users are encouraged to refer to the state mapping documents for information about how the state's system codes its data (National Child Abuse and Neglect Data System, 2011). Also significant to note is that this report does not capture the prevalence of childhood sexual abuse.

Epidemiological studies of childhood sexual abuse have varied. In 1995, Steinberg, citing a 1986 study by Russell, stated, "16% of women in the general American population are sexually abused by a relative before their 18th birthday, and 31% are sexually abused by a nonfamily member" (p. 4). These numbers are low in comparison to Wolfe's 2007 data; she states that sexual abuse estimates "range from 2% to 62% for women and from 3% to 16% for men among U.S. studies" (p. 648). Statistics dating back to 1987 relating to clients in a psychiatric hospital setting reveal "50% to 75% of general psychiatric patients endorsed histories of childhood trauma" (Steinberg, 1995, p. 5).

Who are the perpetrators of childhood sexual abuse? Finkelhor (1979) estimated that 75% to 89% of childhood sexual abuse (CSA) is perpetrated by someone known to the child, for example, family members, relatives, friends of the family, and neighbors.

Furthermore, Fergusson and Mullen (1999) reviewed eight empirical studies on the incidence of CSA dating back to 1990. Data from those studies, according to Rodriguez-Srednicki and Twaite (2006), indicate "18.3 percent of perpetrators were relatives outside the immediate family; 47.8 percent were acquaintances; and 23.4 percent of the perpetrators were strangers," (p. 9). While these data suggest that a much higher percentage of children are abused by someone other than the immediate family members, incest, especially father-daughter incest, also known as "betrayal trauma" (Freyd, 1994), has probably been the subject of more attention in the literature.

Various authors have discussed incestuous family profiles. Green (1996) discusses an authoritarian family structure where the father is often the perpetrator. Rodriguez-Srednicki and Twaite (2006), acknowledging the work of Aarens et al. (1978) state, "an estimated 30 - 40 percent of all cases of CSA are related to substance abuse" (p. 10). Furthermore, Rodriguez-Srednicki and Twaite providing statistics from a 2003 report from the Texas Department of Human Services note:

> At least 30 percent of such fathers have been sexually abused [themselves], and 23 percent had been the victims of emotional abuse or neglect. Additionally, 37 percent of incestuous fathers had witnessed domestic violence as children, and 47 percent had been subjected to physical and/or social isolation during childhood. (p. 10)

Moreover, incestuous families demonstrate "role confusion and a blurring of physical and psychological boundaries" (Green, 1996, p. 76). Because the mother is often emotionally unavailable, the father becomes the primary source of nurturance for his daughter and

provides the nurturance in a sexualized context. In order to remove herself from the aversive situation, the daughter may employ dissociative defenses.

A significant and telling study by Craine, Henson, Colliver, and MacLean (1988) demonstrates the prevalence of a history of childhood sexual abuse among females in a psychiatric state hospital setting in Illinois using a structured interview tool administered by a single interviewer, in addition to reviewing their medical records. A sample of 105 females was selected from approximately 760 patients in nine of the 11 state hospitals that served mentally ill persons to determine if they had been adequately diagnosed and treated for sexual abuse. They found that fifty-one percent had been sexually abused as children or adolescents. "Sixty-percent of those abused met the diagnostic criteria for posttraumatic stress disorder, although none had received the diagnosis" (p. 300). Craine et al. had initiated the study after observing, "certain patients were exhibiting symptoms that were not fully explained by their diagnosis of borderline personality, depression, or schizophrenia" (p. 300). They note the shocking fact that a "number of patients identified as victims were adolescents who had been admitted to the hospital specifically because they had experienced abuse at home" (p. 302). They also point out that "diagnosing posttraumatic stress disorder is often overlooked in the state hospital setting" (p. 303). And I argue, based on years of personal experience while working as a social work administrator in both inpatient and outpatient settings, including in a psychiatric emergency room opened 24/7, that this is still the case today.

It is also often overlooked that males, too, may be the victims of incest since much of the literature focuses on father-daughter incest. Fergusson and Mullen (1999) contend that a "gender bias has obscured issues relating to the sexual abuse of male

children" (p. 35). In 1986, Finkelhor and Baron reviewed the available literature and found that 29 percent of the victims of CSA were male. A later study of the literature by Fergusson and Mullen published in 1999 estimated that approximately 27 percent of victims of CSA were male. A more in-depth review of childhood abuse is found in "*Understanding, Assessing, and Treating Adult Victims of Childhood Abuse*" by Ofelia Rodriguez-Srednicki and James A. Twaite (2006).

Wolfe (2007), commenting on Finkelhor's (1994) review of 19 studies of adult retrospective reports of childhood abuse, states, "approximately 20 percent of women and 5-10 percent of men had at least one episode of sexual abuse during their childhood" (p. 686).

A large study conducted by Fleming, Mullen, and Bammer (1997) found that 25 percent of women had been sexually abused. And again, in the Adverse Childhood Experience study (ACE) in 2003, a managed care program in California, Kaiser Permanente, surveyed 17,337 adult members and found that 25 percent of women and 16 percent of men had at least one episode of abuse during childhood (Wolfe, 2007, p. 686; see also Edwards, Anda, Dube, Long, Chapman, & Felitti, 2005). While these percentages might seem high, the numbers are still low; Wolfe reminds us that some researchers suggest "even in anonymous studies, individuals tend to underreport childhood sexual abuse by at least 16-50%" (p. 686). Clinicians should be aware that males are more reluctant to reveal histories of sexual abuse since it may be regarded as a threat to their masculinity (Lusk & Waterman, 1986). Additionally, males who had conflicting sexual relationships – considered sexual abuse by today's laws – with adult females when they were adolescents or in their early teens may see this as a badge of

honor as in the movie *Summer of '42* (Raucher & Mulligan, 1971). In fact, most cases of abuse of either gender are never reported to police or to other authorities.

Long-Term Psychological Effects of Childhood Maltreatment

With a high percentage of patients presenting for psychological services with histories of childhood maltreatment, what long-term psychological effects might we expect to find? Crooks and Wolfe (2007) state:

> Developmental impairments stemming from childhood maltreatment can lead to more pervasive and chronic psychiatric disorders, including anxiety and panic disorders, depression, eating disorders, sexual problems, and personality disturbances. . . . [While there are many variables to consider] symptoms of depression, emotional distress, and suicidal ideation are common features of individuals of all ages with histories of physical as well as sexual abuse, especially in the absence of positive relationships and opportunities to develop healthy coping strategies and social supports. (p. 644)

Baita (2011), an Argentinean psychotherapist, found that "sexual abuse helps to erase both the client's physical and personal boundaries" (p. 49). It is significant to note that some research studies have found histories of abuse in 82 percent to 98 percent of all cases of dissociative disorders (Coons, Bowman, & Milstein, 1988; Hornstein & Tyson, 1991; Kluft 1988a; Schultz, Braun, & Kluft 1989), while other studies found abuse histories in 72 percent to 98 percent of all reported cases of the dissociative disorders (Kluft, 1988b). Additionally, Steinberg (1994a) asserts, "Dissociative Disorders are currently thought to be more common than originally believed" (p. 7).

Indeed, many experts working in the field of trauma believe that childhood maltreatment has a language of its own, that of dissociative symptoms. Steinberg (1995) contends:

> Only if we understand the core symptoms of dissociation as the sequelae of childhood abuse, as the end results of a child's attempt to assimilate the incoherent jumble of love and pain that characterizes abusive families, we can begin to understand the dissociative disorders as a code language for communicating the unspeakable. (p. x)

Drawing from the 1986 work of Waterman and Lusk, Rodriguez-Srednicki and Twaite (2006) suggest that in order to better understand the language of trauma, clinicians must assess:

> . . . several salient parameters of the sexual abuse experience, including the duration of the abuse, the age of the victim at the time of first occurrence of abuse, the relationship of the perpetrator to the victim, whether or not the abuse involved oral, anal, or vaginal penetration, whether the perpetrator used force and whether or not the perpetrator used threats or coercion. (p. 6)

Moreover, in the Frequently Asked Questions (FAQ) section of the ISSTD website, Goldman (2010) is quoted as follows:

> Children are more vulnerable than adults because their brains are not mature enough to integrate what has happened: the younger the age, the more likely trauma related disorders will develop. . . . Abused children are 25% more likely to experience teen pregnancies, 59% more likely to be arrested as a juvenile, 30% more likely to commit violent crime. Such children fill our prisons; they abuse

> alcohol at 2.5 times the rate of the general population, and drugs at 3.5 [times] the rate. An overwhelming two-thirds of those in drug rehabilitation report a history of child abuse. (p. 13)

It is also significant that non-family members who are perpetrators of sexual abuse often threaten the child with killing family members or tell the child that her mother will not love her — emotional abandonment — or that the child will be blamed and seen as bad if she tells anyone about "our little secret." Betrayal trauma (Freyd, 1994), sexual abuse committed by a trusted family member, may contribute to more severe pathology and extreme dissociation as will be discussed later in this study.

In summary, empirical studies reveal that childhood sexual abuse, of both male and female children, is prevalent in Western society and can contribute to the development of dissociative defenses to cope with the trauma. Additionally, empirical studies have demonstrated that there is a high prevalence of female patients in psychiatric hospital settings with a history of childhood sexual abuse. These patients include sexually abused adolescents who were misdiagnosed by omitting the diagnostic category of posttraumatic stress disorder.

CHAPTER THREE: UNDERSTANDING THE PHENOMENOLOGY OF DISSOCIATION

Dissociation: Definition and Origins

Many contemporary researchers are in agreement concerning the general phenomenology of dissociation (Steinberg 1995, p. 20). The American Psychiatric Association (*DSM-IV-TR,* 2000b) defines dissociation as, "a disruption in the usually integrated functions of consciousness, memory, identity, or perception" (p. 519). Several authorities in the field of complex trauma offer similar variations of *DSM-IV-TR's* definition. West (1967) defines dissociation as:

> A psychophysiological process whereby information—incoming, stored, or outgoing—is actively deflected from integration with its usual or expected associations . . . [and as a] state of experience or behavior wherein dissociation produces a discernable alternation in a person's thoughts, feelings, or actions, so that for a period of time certain information is not associated or integrated with other information or logically would be. (p. 890)

Dissociation is also described by Putnam (1989) as:

> an ongoing process in which certain information (such as feelings, memories, and physical sensations) is kept from other information with which it would normally be logically associated. Dissociation can be a psychological defense mechanism that also has psychobiological components. Generally, it is thought to originate in a normal process that is initially used defensively by an individual to handle traumatic experiences [that] evolve over time into a maladaptive or pathological process. (p. 9)

Stating it in a slightly different way, Spiegel and Cardena (1991) define dissociation as "a structured separation of mental processes (e.g., thoughts, emotions, conation, memory, and identity) that are ordinarily integrated" (p. 367). Steinberg (1995) expands upon Spiegel and Cardena's definition stating, "Any human psychological or behavioral function may become dissociated from consciousness" (p. 21). In fact, Steinberg's definition sounds similar to Braun's (1988) BASK model. Braun, another early contemporary pioneer in the field of dissociation, proposed using the mnemonic, "BASK" to describe dissociating any or all of the following elements, Behavioral, Action, Sensation, and Knowledge, which function along a time line and may be dissociated from consciousness.

Perhaps the most recent attempt to clarify the phenomena and pathogenesis of dissociation is addressed in *Dissociation and the Dissociative Disorders: DSM-V and Beyond* edited by Paul Dell and John A. O'Neil, (2009), a book that is meant to prepare clinicians for the release of the next edition of the diagnostic and statistical manual, the DSM-V. Thus, the book provides the diverse theoretical history of the study of dissociation beginning with animal magnetism leading to the most contemporary body of literature that contributes to a more comprehensive understanding of the concept of dissociation and the diagnostic categories of DID and DDNOS.

I will draw on van der Hart and Dorhay's (2009) in-depth review of the history of dissociation to provide a brief synopsis here. As far back as the 16th century, *possession* by devils and demons was believed to be the etiology of more than one personality; the case of Jeanne Fery is an example. In 1791, in Germany, "Eberhardt Gmelin published the first treatise on a case of *double personality*" [italics added] (van der Hart & Dorhay,

p. 4). In the United States in 1816, S. L. Mitchell presented the case of Mary Reynolds with *multiple personality,* which is believed to be the most complex form of hysteria. However, the initial reports using the term "*dissociation*" came from the "French pioneers and very early investigators of animal magnetism and hypnosis" (p. 4).

In Vienna, in 1779, Franz-Anton Mesmer introduced the theory of animal magnetism before the concept of hypnotism existed. This theory postulates that "nervous illness . . . results from an imbalance between the animal magnetism ['fluid'] in the patient's body and the external world at large, which can be redressed by human agency" (Gregory, 1987, p. 477). Gregory further states that Mesmer believed he could correct the patient's nervous imbalance

> . . . by channeling animal magnetism [fluid] through his own body to that of the patient, whether by directly applying hands on to the affected part ("passes") [of the body] or indirectly by requiring the patient to grasp an iron bar which he had previously "magnetized" by direct contact. (p. 477)

Mesmer's theory was eventually discredited by scientists and "merged into hypnotism or more broadly, psychological medicine" (p. 478).

Mesmer's work was followed by that of his student Amand-Marie-Jacques de Chastenet, Marquis de Puysegur, who discovered that some subjects entered a state of consciousness where they were aware of only the magnetizer's [hypnotizer's] commands. When emerging from this induced state referred to as *artificial somnambulism* they were amnesic of what had transpired. Van der Hart and Dorhay (2009) report that Braid referred to this condition in 1843 as *hypnosis* (p. 4). Forrest (1999), quoting the point of view of Puysegur and his colleagues, writes, "the line of demarcation [in the personality

during artificial somnambulism] is so complete that these states may almost be described as two different existences" (p. 95). Van der Hart and Dorhay further state that "Puysegur observed that an individual in a somnambulistic state (either natural or artificially induced) displayed two separate streams of thought and memory, in which, at any particular moment, one stream operated outside conscious awareness" (p. 5).

Our contemporary understanding of this division of consciousness may date back to around 1836 when Antoine Despine, a French general practitioner and "fashionable spa doctor" (Hacking, 1995, p. 45), linked "splitting of consciousness in hypnosis and the clinical phenomena of hysteria" (van der Hart & Dorhay, 2009, p. 5). Despine is noted for being the first clinician to treat a dissociative child, 11 year-old Estelle. He also appears to be the first person to cure a person with multiple personalities using a non-exorcist treatment modality (Hacking, p. 45).

Next to present research on the division of consciousness was the French psychiatrist Moreau de Tours (Crabtree, 1993; van der Hart & Horst, 1989). Van der Hart & Dorhay (2009) tell us that while studying the effects of hashish, a chemically induced dissociation, in 1845, Moreau de Tours concluded:

> The action of hashish weakens the will—the mental power that rules ideas and associations and connects them together. Memory and *imagination* [italics added] become dominant; present things become foreign to us, and we are concerned entirely with things of the past and the future. . . . Dissociation—or disaggregation (*desagregation*)—was the splitting off or isolation of ideas, a division of the personality. (p. 5)

Later, in 1859, Briquet called "magnetic somnambules [hypnotics] . . . hysterical women" (van der Hart & Dorhay, 2009, p. 6). Charcot further expanded on these ideas in 1887, theorizing that "hysterical symptoms (e.g., paralyses, contractures) were based on subconscious ideas that had become separated from consciousness" (p. 6). In 1907, Pierre Janet, originally a philosopher and experimental psychologist who had become a psychiatrist and the leading scientist at the Salpetriere in France, postulated that both somnambulism and hysteria should be "based upon a division of the personality" (p. 6). Janet considered hysteria to be "an illness of the *personal synthesis"* (p. 7) or a mental depression, thus acknowledging a role for constitutional vulnerability. Janet's theory, which includes the introduction of a three-stage oriented treatment model, will be revisited later in this study when reviewing van der Hart, Nijenhuis, and Steele's (2006) new theory of structural dissociation. In the 19th century, *multiple personality disorder* received a great deal of attention and the term *dissociation* was rarely used. However, William James (1890), who was inspired by Janet, addressed dissociation, which he referred to as a division of consciousness in his opus, *The Principles of Psychology.*

At the beginning of the 20th century the American clinicians who began studying dissociation included Boris Sidis and Morton Prince. "For Sidis, loss of memory was the essential indicator of the dissociative effects of 'hurtful stimuli'" (van der Hart & Dorhay, 2009, p. 11). Prince (1906), who may be best remembered for his multiple personality case, Miss Beaucham, while also influenced by the work of the French theorists, was not totally accepting of their theories. Van der Hart and Dorhay (2009) report that Prince, taking the opposite view of J. Janet and Azam, theorized that the "hysteric" part of the personality was not the core part or the original part of the personalities. Rather, the

hysteric part was a "secondary, dissociative, or disintegrated state that was characterized by both positive and negative 'physiological' (i.e., somatic) and psychological symptoms (i.e., 'stigmata')" (p. 5), while the normal part of the personality lacked symptoms. Prince suggested that these personalities, especially the hysteric part, could split multiple times with the various personalities alternating with each other; a process now referred to as "*switching.*" Prince (1909) also believed that dissociation was a mechanism that was not solely pathological, but a normal function. However, van der Hart and Dorhay state:

> Unlike contemporary ideas of a continuum of dissociative experiences that emphasize dissociative phenomenology, Prince remained firmly focused on the structural elements and psychic functioning and how psychological systems and complexes (associated ideas) become disconnected and synthesized. (p. 12)

Overall, it appears that Prince was less interested in the etiological factors of dissociation and more interested in the structure and organization of the personality, which will also be explored later under the new structural dissociation model of van der Hart et al. (2006).

During the 20th century, due to WWI, dissociation also received attention from British Army psychiatrists, especially Charles Samuel Myers (1940). Drawing from Pierre Janet's dissociation theory, Myers found that traumatized combat soldiers had a mental condition best described as a (dissociated) personality, that is, an "emotional" personality. Meyers conceptualized that the soldier's failure to integrate the various sensory and psychological aspects of horrific experiences had led to a division of the personality into an "apparently normal personality" and an "emotional personality" (van der Hart & Dorhay, 2009, p. 12). In keeping with contemporary knowledge, Myers was

also aware of somatoform dissociation, which will be explored further under Ogden's body oriented theory, Sensorimotor Psychotherapy.

Dissociation in the Psychoanalytic Literature

Breuer and Freud

According to van der Hart and Dorhay (2009), Breuer and Freud disagreed with Janet's theory that "splitting of the mind" or "splitting of consciousness" was due to a "constitutional predisposition to mental weakness . . . that gave rise to hysteria" (p. 14). Instead, they postulated that dissociation caused a mental weakness. Furthermore, Freud perceived dissociation as an ego defense. In fact, dissociation was the "first identified mechanism of ego defense in psychoanalysis" (p. 13). While initially Freud attributed childhood abuse to the etiology of hysteria, he renounced this theory in favor of his new repression model with an instinctual drive theory, with intrapsychic conflict leading to the development of hysteria and other neurotic forms. More definitive conceptualizations of dissociation remained the task of other writers, including Ferenczi and the object relations theorists (p. 14).

Salvador Ferenczi

Ferenczi (1933/1949), a WWI army psychiatrist who understood the effects of trauma, argued emphatically that dissociation or splits in the personality were related to childhood trauma:

> If the shocks increase in number during the development of the child, the number and the various kinds of splits in the personality increase too, and soon it becomes extremely difficult to maintain contact without confusion with all the fragments,

> each of which behaves as a separate personality yet does not know of even the existence of the others. (p. 229)

Ronald Fairbairn

Fairbairn (1944), an object relations theorist, postulated that dissociation was the basis of hysteria:

> Here it may be added that my own investigations of patients with hysterical symptoms leaves me in no-doubt whatever that the dissociation phenomena of "hysteria" involves a split of the ego fundamentally identical with that which confers upon the term "schizoid" its etymological significance. (p. 92)

Thus, the terms "dissociation," "schizoid," and "splitting of the ego" in Fairbairn's view "were interchangeable terms that referred to a specific type of division in psychic organization" (van der Hart & Dorhay, 2009, p. 15). Fairbairn's theories will be discussed again in the overview of trauma.

Herbert Spiegel

Herbert Spiegel, according to van der Hart and Dorhay (2009), referred to "the term *dissociation* . . . [as both] a defensive process . . . and as a conceptual framework (i.e., the dissociation-association continuum)" (p. 15), eliminating the need to refer to instinctual conflict. Spiegel (1963) further defined dissociation as a "fragmentation process that serves to defend against anxiety and fear (or instinctual demands)" (p. 375). Spiegel's continuum model suggested that dissociation ranged from being a defense against anxiety that constricted awareness, to a "strategy designed to sustain adaptive level of awareness, to the (re)integration of dissociated fragments increasing awareness and allowing for more creativity and growth" (van der Hart & Dorhay, p. 12).

Ernest Hilgard

Hilgard, a researcher in hypnosis and altered states of consciousness, also developed an interest in dissociation. In 1974 Hilgard conducted his famous "reference experiment" (p. 307).

> [He] induced in highly hypnotizable students analgesia for cold-pressor pain (i.e., from immersion of an arm in ice-cold water) . . . [and discovered] that he could use automatic writing or talking to communicate with a "subconscious" part of the individual [referred to as the "hidden observer"] that reported feeling the pain and discomfort that the hypnotized person did not feel. (van der Hart & Dorhay, 2009, p. 17)

Later, Hilgard (1977) outlined this and other experiments that were the basis for his neo-dissociation theory in his monograph, *Divided Consciousness: Multiple Controls in Human Thought and Actions,* and in additional papers. While Pierre Janet and other investigators who had previously identified "vertical splits" in consciousness influenced Hilgard's neo-dissociation theory, it differed from classic models of dissociation that emphasized splits in the ego. Indeed, Hilgard's (1973) neo-dissociation theory provided the explanation that "separate controls operate within a common nervous system" (p. 215; see also Kihlstrom, 1984, p. 189). For example, his theory "brought into the domain of dissociation the simultaneous performance of two cognitive activities (e.g., driving a car while simultaneously being deeply absorbed in a day-dream or conversations)" (van der Hart & Dorhay, 2009, p. 17).

In summary, Hilgard's (1973) neo-dissociation theory provided a new framework for understanding multiple personality, which he called an example of "dissociation *par*

excellence" (p. 216). Following Hilgard, the study of dissociation in the late 1970s focused on multiple personality with an increased number of cases being identified in North America. Unfortunately, there were no scientific journals to guide clinicians in their quest for knowledge. Therefore, they communicated informally through personal dialogue and later more formally through conferences. However, the enthusiasm for studying dissociation was not shared by all clinicians and still today skepticism remains as to whether or not the dissociative disorders actually exist. Yet, in spite of the disbelievers, the interest in researching the field is growing by leaps and bounds with new scientific evidence being contributed by the field of neuroscience.

Understanding the Process of Dissociation

It is important for clinicians to understand what the process of dissociation serves, and to be able to distinguish between normal and pathological dissociation during patient interviews. Steinberg (1995), provides an outline of Ludwig's 1983 proposal, which lists six main functions for the mechanism as follows: (a) "automatizing behavior in which dissociation increases efficiency by allowing a person to perform actions without direct consciousness attention" (p. 25); and (b) resolution of irreconcilable conflicts, which allows a person with cognitive dissonance to separate conflictual desires, or to separate a conflict between attitudes and behavior. In other words, a person knows the bad consequences of an action but does not stop the behavior because it is on a different level of consciousness. (c) escape from reality, which allows a person to dissociate and "*imagine* [*italics added*] that they have some kind of mastery over intractable environmental difficulties" (p. 25). It is not uncommon for abused children to engage in magical thinking to retain an illusion of control over the situation (e.g. believing that they

caused the perpetrator to act out provides an illusion of control. In fact, if a child can predict that they will be abused, they may initiate it to get it over with); (d) isolation of catastrophic experiences where "dissociation may function to seal off overwhelming trauma into a compartmentalized area of consciousness until the person is better able to integrate it into mainstream consciousness" (pp. 25-26); (e) cathartic discharge, which in some cultures serves as a ritual for the periodic "release of pent-up emotion or to dissociate inhibitions that normally block the feeling" (p. 26); and (f) dissociation contributes to enhancement of human bonding where a person falls prey to charismatic leaders and causes. This function of dissociation also serves to explain the vulnerability of abuse survivors to revictimization by a trusted member of the helping profession, including clinicians and clergy, or to brain washing of any kind. In fact, several adult patients, both male and female, with a dissociative disorder who were seen in my private practice reported being sexually violated multiple times by a clinician, and the violation began as a part of a therapeutic intervention.

When explaining dissociation to a patient with complex trauma they will often ask how their dissociative syndrome differs from the "normal" dissociation that everyone experiences (e.g., when someone daydreams or simply *spaces-out* and misses their exit from the freeway). Steinberg (1995) writes, the difference is that "a normal person experiences identity alteration in terms of integrating different roles, is aware of the role transition, and understands it is within his or her conscious control" (p. 24). Steinberg, drawing from Putnam (1985), reminds clinicians that even in "normal dissociation" the range varies according to the stages of the human life cycle (p. 24). For example, the range is wider in children and they dissociate more freely than adults. In fact, Wieland

(2011) drawing from the work of Baum (1978) and Trujillo, Lewis, Yeager, and Gidlow (1996) writes:

> Fantasy stories and characters created by the preschool child often take on a separate reality. Imaginary playmates may be an enjoyable fantasy, an expansion of experience, a way to fill loneliness or boredom, or a process for working out fears and ambivalent feelings. (p. 2)

It is my belief that, over time, the non-pathological behavior of young children to utilize fantasy to create imaginary playmates becomes a contributing factor in severe dissociation to the etiology of alter parts of the personality for those children who are being abused. The specific characteristics of these alter parts for those abused children will be discussed subsequently.

Understanding the Process of Consciousness

Central to the concept of dissociation is the concept of consciousness defined from a clinical perspective by Steinberg (1995) as a mental domain containing the "sensations, perceptions, and memories of which a person is momentarily aware" (p. 22). Steinberg further explains that "*Reflective* consciousness is critical to human functioning, and fragmentation of consciousness by a dissociative disturbance impacts a person's sense of selfhood or basic humanity." He states that when William James declared, "'I feel, I think,' [he was stressing] the concept of interdependence of consciousness and identity and was defining consciousness as 'self reference'" (p. 22).

Consciousness is also a structured process, "that functions to encode, process, and communicate information" (Steinberg, 1995, p. 22). The components of consciousness include memory storage and retrieval, a sense of being oriented to reality

and an awareness of one's existence and identity. Steinberg further notes, "the normal process is for humans to integrate these components into a global experience accessible to introspection in the present moment and recall in the future" (p. 22). Moreover, Steinberg states,

> There is also an inexpressible subjectivity composing one particular level of consciousness — what Kihlstrom terms *phenomenal awareness* — which is the presence of information in the brain, along with a *feeling* — an affect that confers an internal reality on human thoughts. (p. 22)

Steinberg further tells us that Kihlstrom posits two principles associated with consciousness: "(a) self-monitoring and environmental monitoring to ensure accurate representations of percepts, memories and thoughts in phenomenal awareness, and (b) control of self and environment in order to voluntarily initiate and terminate thoughts and behavior" (p. 22).

Other writers have different interpretations. William James (1890) as paraphrased by Steinberg, (1995) claimed: "The fundamental aspect of consciousness was the continuity of experience, underscoring the essential underlying features of integration, organization, and singularity in consciousness" (p. 23).

It also important to note, that *dissociation* and *repression,* introduced by Janet and Freud respectively are not the same. According to Steinberg (1995, p. 26), *repression* refers to intrapsychic pain and removal of unacceptable ideas from consciousness by a strong ego, which preserves the patient's "sense of self." Additionally, in *repression,* mental contents are separated from consciousness, but the psychological processes are not affected. In contrast, *dissociation* refers to the avoidance of pain from an external

source and the "ego's allowing itself to fall apart" (Steinberg, 1995, p. 27) with the person experiencing themselves as fragmented. These patients' ideas are out of awareness and they have several different centers of consciousness, or multiple realities, which contributes to high anxiety.

In an effort to clarify the concepts of repression and dissociation, Stephen Braude (2009) states, "Both concern psychological barriers, but they differ in scope, function, and vulnerability" (p. 30). According to Braude, Hilgard's (1986) use of metaphors refers to repression as a horizontal split and dissociation as a vertical split. Braude states that some writers "describe repression as a defensive barrier preventing certain mental states from becoming conscious. In contrast, dissociative barriers can hide both mental and physical states from conscious awareness" (p. 30). Braude also points out that different methods are used to gain access to the hidden or buried psychic material. Whereas repressed material has been viewed as symbolic and accessed through by-products such as dreams and slips of the tongue or through primitive process thinking, dissociated material is viewed differently. In contrast, dissociated states may be accessed more directly by hypnosis, automatic handwriting or in the case of DID by speaking directly to alter identities. Although clinicians new to treating DID will initially find it awkward to speak directly to alter parts, it is a very effective intervention that promotes a secure attachment to the whole client. Said differently, it is important to form a secure attachment to all the alter parts. The challenge for the clinician is to be sensitive to the fact that not all the alters will begin to trust at the same time. Additionally, not all alters will communicate in the same manner. For the clinician, learning the idiosyncratic

communication styles of the alters is akin to the mother learning her baby's different attachment cries (p. 30).

Armed with a basic understanding of the concepts of dissociation and consciousness, we can now turn to an overview of the various dissociative disorders as defined in multiple editions of the DSM.

The Dissociative Disorders

Steinberg (1995) describes the dissociative disorders as "a group of related disorders with symptoms reflecting a disturbance in the integrative functions of memory, consciousness and/or identity" (p. 7). Steinberg further points out:

> Until 1980, dissociative disorders were classified as a subcategory of hysteria, conversion disorders being the other subcategory. In 1980, *DSM-III* (American Psychiatric Association) introduced the term *dissociative disorders*, thus breaking from previous psychoanalytic definitions. (p. 20)

Later, in the *DSM-III-R* (1987a), the APA identified the five dissociative disorders as (a) psychogenic amnesia, (b) psychogenic fugue, (c) depersonalization, (d) multiple personality disorder, and (f) dissociative identity disorder not otherwise specified (DDNOS) to accommodate dissociative disorders that appear in specific cultural contexts (pp. 157-159).

Additionally, in the *DSM–III–R*, the five dissociative disorders were separated from conversion disorders (Nemiah, 1991). Dissociative trance disorder was later added in the DSM–IV as a subcategory of DDNOS to "accommodate cultural contexts that involve an involuntary state of trance that is not part of the accepted culture or religious practices and that cause's clinically significant distress" (Steinberg, 1995, p. 21).

The five dissociative disorders listed in *DSM-IV-TR* (American Psychiatric Association, 2000b) are dissociative amnesia, dissociative fugue, dissociative identity disorder or DID [formerly MPD], depersonalization disorder, and dissociative disorder not otherwise specified (DDNOS). For an extensive review of their diagnostic criteria and associated features the reader is referred to the *DSM-IV-TR* (American Psychiatric Association, 2000b). This dissertation will focus primarily on Dissociative Identity Disorder (DID), considered the most severe of the dissociative disorders and perhaps the most challenging to diagnose and treat. The diagnosis of DDNOS, which will also be mentioned, is similar to the diagnosis of DID, but fails to meet the full criteria. This will be explained more fully in the discussion of the new structural dissociation model authored by van der Hart. Nijenhuis, and Steele (2006).

Diagnosing Dissociative Identity Disorder

The *DSM-IV-TR* (2000b) defines the following diagnostic criteria for Dissociative Identity Disorder:

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behavior.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g. blackouts or chaotic behavior during Alcohol Intoxication) or a general

> medical condition (e.g. complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play. (p. 529)

Diagnosing DID is challenging in that it often mimics other psychiatric conditions, including the psychotic, affective, and personality disorders (Bliss 1980; Braun & Sachs 1985; Coons 1984; Greaves 1993; Kluft 1984, 1987; Putnam, Guroff, Silberman, Barban, & Post, 1986). Patients may experience hallucinations and endorse first-rank Schneiderian symptoms which contribute to confusion with Schizophrenia (Bliss 1980, 1986; Kluft 1984, 1987; Rosenbaum 1980; Ross & Norton, 1988) depressive symptoms, which contribute to confusion with affective disorders (Bliss 1986; Coons, 1984; Kluft 1985b, 1987; Marcum, Wright, & Bissell, 1986; Putnam et al. 1986), and a chaotic life–style, which contributes to confusion with Borderline Personality Disorder (Clary, Burstin, & Carpenter, 1984; Horevitz & Braun, 1984).

In fact, people with dissociative disorders often receive many diagnoses before being diagnosed accurately. A study by Putman (1998) of diagnoses previously given to DID patients found that 70% had a diagnosis of depression, 55% had neurotic disorders, 46% had personality disorders, 44% had been diagnosed with Schizophrenia, 20% with substance abuse, and 18% with Bipolar Disorder. Steinberg contends that at least a decade may elapse from the time a patient with DID first seeks mental health treatment until a correct assessment with appropriate treatment begins. The International Society for the Study of Dissociation (ISSD later changed to ISSTD) Guidelines for Treating DID in Adults (2005) state:

> A careful clinical interview and a thoughtful differential diagnosis can usually lead to the correct diagnosis in persons who have DID (Coons, 1984). . . . The patient should be asked about episodes of amnesia, fugue, depersonalization, derealization, identity confusion, and identity alteration (Steinberg, 1995), age regressions, autohypnotic experiences, hearing voices (Putnam, 1991a), passive-influence symptoms such as "made" thoughts, emotions, or behaviors (Dell, 2001; Kluft, 1987), and somatoform symptoms such as bodily sensations related to past trauma (Nijenhuis, 1999). (p. 77)

Furthermore, according to the ISSD Adult Guidelines (2005, p. 78) it is important for clinicians to keep in mind that some persons with DID do not realize that their internal experience is different from that of other persons. Alternate identities, along with other dissociative symptoms, are commonly disavowed because dissociation is a defense against uncomfortable realities.

The ISSD Guidelines (2005), referencing Putnam et al. (1986), state that "the diagnosis of DID, is nearly universally associated with an antecedent history of significant traumatization – most often first occurring in childhood" (p. 78). Steinberg (1994a), drawing from Kluft, Steinberg, and Spitzer (1988) states, "Dissociative Identity Disorder (Multiple Personality Disorder) is the most chronic and severe manifestation of dissociative processes. . . . [Furthermore, it] is believed to follow severe and persistent sexual, physical, or psychological child abuse" (p. 8). Therefore, the diagnostic assessment should attempt to outline the patient's trauma history. However, the ISSD Adult Guidelines for Adults (2005) cautions clinicians to use clinical judgment about "how much detail of traumatic experiences to pursue during the initial interviews,

especially when those experiences seem to be poorly or incompletely remembered" (p. 78). Further, the ISSD Guidelines caution against evoking a florid decompensation of the patient who might experience severe posttraumatic and dissociative symptoms.

Having noted that empirical studies demonstrate a strong causal link between early childhood maltreatment and a dissociative disorder that may manifest in the adult patient, especially when sexual abuse has occurred, it is an ethical concern that therapists may not be asking the patients questions about their developmental history with a focus on traumatic life events. In fact, it has been my experience working as a Licensed Clinical Social Worker in an administrative position for a community mental health clinic reviewing hundreds of medical records over two decades, that therapists tend to scantily document a developmental history with minimal, if any, trauma history for the adult patient. An additional finding of mine is that when a trauma history has been documented, rarely is a diagnosis of PTSD considered. Even less frequently is a diagnosis of DID or DDNOS considered even when an adequately documented history and matching symptomatology is provided. This dissertation will also mention interview tools that will assist the clinician to make an accurate assessment leading to a correct diagnosis and appropriate treatment plan.

Diagnosing Dissociative Identity Disorder Not Otherwise Specified

The category Dissociative Disorders Not Otherwise Specified (DDNOS) is defined in the *DSM-IV-TR* (2000b) as a "disorder in which the predominant feature is a dissociative symptom (i.e. a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment) that does not meet the criteria for any specific dissociative disorder" (p. 532). Examples include

presentations where there are not two or more distinct personalities or when amnesia is lacking.

Diagnostic Instruments for Assessing Dissociative Disorders

The ISSD Guidelines for Treating Dissociative Identity Disorder in Adults (2005) state, "There are three classes of instruments that assess dissociation: clinician-administered structured interviews, clinician-administered measures, and self-report instruments" (p. 78). There are two clinician-administrated structured interviews, the Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D-R) (Steinberg, 1994a, 1994b) and the Dissociative Disorder Interview Schedule (DDIS) (Ross, 1997).

The SCID-D-R Structured Clinical Interview

Although dissociative disorders have been observed from the beginning of psychiatry, prior to 1985 there were no instruments specifically designed to diagnosis the disorders (Kluft 1993b; van der Hart & Friedman, 1989). In 1985, Marlene Steinberg created the *Structured Clinical Interview (SCID-D) for DSM-III-Revised Dissociative* Disorder (Steinberg, Rounsaville, & Chiccetti, 1990). This was the first diagnostic instrument "designed for the comprehensive evaluation of dissociative symptoms and disorders" (Steinberg, 1994a, p. ix). The revised SCID-D-R instrument for the *DSM-IV* is a 227-item, semi-structured clinical interview designed in a manner that allows the trained clinician to assess the nature and severity of the dissociative symptoms, thus accurately diagnosing the presence of Dissociative Disorders in adults. This is in contrast to the highly structured Dissociative Disorder Interview Schedule (DDIS), a 132-item tool, which provides a yes-or-no checklist of numerous symptoms that are found in many

psychiatric disorders. In comparison, the SCID-D-R is designed with open-ended questions that elicit elaborate descriptive responses and allow for follow-up questions of endorsed symptoms. The SCID-D-R takes approximately one hour to 1.5 hours or more to administer depending on the number of positive responses and the amount of time patients spend elaborating on their answers. The SCID-D-R has good-to-excellent reliability and discriminate validity (ISSD Guidelines, 2005, p. 79) and may be administered by any trained clinician. In my practice, I have found that it can take a longer amount of time if a manipulating alter identity is answering the questions. This will be discussed under case material.

In addition, the SCID-D-R questions explore the frequency, course, dysfunction, and distress associated with dissociative symptoms, which, according to Steinberg (1994a), will meet the growing "need for systematic assessment to improve diagnostic accuracy and allow for appropriate treatment" (p. ix).

The SCID-D-R structured interview tool consists of 8-parts beginning with the Psychiatric History section followed by a section on each of the following: Amnesia, Depersonalization, Derealization, Identity Confusion, Identity Alteration, Associated Features of Identity Disturbance, and follow-up sections on Identity Confusion and Identity Alteration. According to Steinberg (1994a, p. ix), in addition to assessing dissociative symptoms in a variety of Axis I and II psychiatric disorders, including the anxiety disorders (such as Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder), affective disorders, psychotic disorders, eating disorders and personality disorders, the SCID-D-R was developed to reduce the variability in clinical diagnostic

procedures and was designed for use with psychiatric patients as well as with non-patients (e.g. community subjects or research subjects in primary care).

The SCID-D-R's main goal, the assessment of dissociative symptoms, "is done independently of the diagnosis" (Steinberg, 1994a, p. ix). The SCID-D-R interview begins with an overview of the subject's current level of functioning and their psychiatric history utilizing screening questions. In a systematic manner, the SCID-D-R then inquires about specific symptoms [and functioning]. Utilizing the optional follow-up sections the interviewer can choose to explore the extent of identity disturbance.

In making a diagnosis, Steinberg (1994a) also allows for the use of "intra-interview cues suggestive of dissociative symptom and/or disorders" (p. ix). All cues are assessed and recorded in a systemic manner after the interview. In a similar fashion, the Sensorimotor Psychotherapy model (Ogden, Minton, & Pain, 2006) also encourages the clinician to pay attention to the nonverbal communications during the assessment. Examples of these cues include:

> voice tone, volume, lack of eye contact or aggressive staring, unusual or stereotypical movements or physical positions such as bracing, lowering of the head, freezing, rocking, or sexualized positions. . . . Unexpected and repeated shifts in tone and volume of voice, physical postures, movement patterns, and topics of conversation may indicate alternations between dissociative parts. (van der Hart et al., 2006, p. 222)

Steinberg cautions the clinician to just take note of them and suspend judgment as to their meaning until sufficient data has been gathered to make a diagnosis. Moreover, Steinberg contends that the incorporation of the intra-interview cues into the SCID-D-R ratings,

along with the patient's verbal responses, "best approximates a clinical diagnostic interview while maintaining the consistency of a structured interview" (Steinberg, 1995, p. x). Furthermore, Steinberg states, "because the clinician can offer hope for full recovery to most patients with dissociative disturbances, accurate diagnosis and proper treatment are genuinely beneficial – to the patient and to the rest of society" (p. 3).

Braude (2009), who holds a bias toward diagnostic surveys, argues that while the diagnostic surveys were originally intended to be utilized as screening instruments:

> some clinicians have examined the concept of dissociation using diagnostic surveys (e.g. the Dissociative Experience Scale (DES) and the Multiscale Dissociation Inventory (MDI)) to consider how dissociative symptoms cluster. . . . However, the results after subsequent research on thousands of survey results . . . [still can't tell us definitively] what *dissociation is*. (p. 28)

Braude further argues that the surveys are "limited by their selective grasp of the history of the concept and they tend to neglect many non-pathological hypnotic phenomena" (p. 28).

Additionally, I have found in my own work with clients in our contemporary western culture that the diagnosis of DDNOS or DID is somewhat more readily accepted when they understand, as research indicates, that dissociative symptoms are complex posttraumatic symptoms related to an experienced trauma (Fine 1990; Kluft 1985b; Spiegel 1991; Terr 1991). Since a comprehensive review of all five dissociative disorders listed in the *DSM-IV-TR* (2000b) is beyond the scope of this dissertation, the reader is directed to Marlene Steinberg's (1995) *Handbook for the Assessment of Dissociation: A Clinical Guide* or the *DSM-IV-TR*. We will now turn to a discussion on

the attitudes of professionals in regards to diagnosing dissociative disorders and of their denial of childhood maltreatment.

Professional Denial of Childhood Maltreatment and Its Effect When Assessing and Diagnosing Dissociative Disorders

Assessing and accurately diagnosing clients with dissociative disorders, also referred to in the contemporary literature as complex posttraumatic syndromes or complex trauma disorders, proceeds from two premises. The first premise, according to Steinberg (1995) is that the assessment and diagnosis of dissociative disorders are "complicated by the silence of the client" (p. xi). Further expanding on the notion of silence, Davies and Frawley (1994), explain, "The abused child becomes encased within her own world . . . perpetually without the language to announce what is happening to her." (p. 54). In other words, she lives in a wordless world. Moreover, "the client is unable to symbolize with language, and reenacts an aspect of the dissociated trauma" (L. Kahn, 2006, p. 2). The second premise, according to Steinberg (1995) is, "Recovery begins when the patients are able to speak of their experiences and be heard and understood" (p. xi). Steinberg believes that dissociative disorders have a good prognosis in most cases and that "the therapist who works with dissociative patients can have real hope that he or she is making a positive contribution by helping these patients to find their voices again" (p. x).

It is interesting to note that in 1995 Steinberg wrote, "The effective detection and treatment of the dissociative disorders [has been challenged by] . . . the collective silence of psychiatric professionals, broken only within the past 5 years" (p. xi). She postulated that researchers in the field of dissociative disorders have begun to address their

professional denial. Yet, sixteen years later, in an effort to address a concern for the low numbers of psychiatrists belonging to the professional society, Vedat Sar, M.D., (2008) then President of the International Society of the Study of Trauma and Dissociation (ISSTD), made the following comments in the ISSTD newsletter:

> Relying solely on a "medical model" of treatment prevents clinicians from satisfying the needs of persons who are faced with developmental trauma. When patients fail to respond to routine medical or psychiatric interventions, they are said to have "treatment resistance" or have a "so called axis-II psychopathology" because developmental trauma is not fully understood . . . Many patients experiencing complex dissociative disorders are not considered by clinicians as having "an enduring" disorder because they usually seek treatment for flashbacks, mental intrusions, hallucinations, loss of behavioral control, and suicidal ideation. A thorough evaluation may reveal frequently occurring dissociative symptoms (micro-amnesias), irritability, mood fluctuations, problems with interpersonal detachment, etc. . . . These clients are seen by their clinicians as having repetitive, periodic, transient, acute dissociative disorder rather than a complex chronic condition. (p. 1)

Sar's clinical opinion is supported by a 2008 study by Foote, Smolin, Neft, and Lipschitz regarding clients with consecutive admissions to an acute psychiatric unit. Brad Foote, a member of the ISSD Research Planning Conference (RPC) and appointed Director of the Field Trials on Dissociative Disorders, in preparation for *DSM-IV*, found suicidality was more likely to be associated with dissociative disorders as opposed to a borderline personality disorder.

Sar (2008) further posits, "Among adolescents in inpatient psychiatric units, complex dissociative disorders are one of the most frequently observed causes of hospitalization as a result of impulsivity, disruptive behavior, substance abuse, and suicidality" (p. 3). Many authors support Sar's view that there is "compelling evidence that substance abuse and violent behavior may be related to childhood trauma and dissociation" (p. 4). To make a point for this compelling evidence, Sar notes that in a 2005 study utilizing Steinberg's SCID-D based interview-screening tool with detoxified adolescent substance users, Karadag, Sar, Tamar-Gurol, Evren, Karagoz, and Erkiran found that "17 percent had a dissociative disorder. . . . [Additionally,] 68 percent of those adolescents diagnosed with a dissociative disorder reported experiencing dissociative symptoms an average of 3.6 years (range 1-11) prior to using substances (p. 4).

A study conducted at McLean Hospital in 1997-1998 by Lalonde, Hudson, Gigante, and Pope (2001) surveyed board-certified psychiatrists (N=406) to determine what they thought about including "dissociative amnesia" and "dissociative identity disorder" in the *DSM-IV*. In this study, only "about one-third of respondents thought that these diagnosis should be included without reservations in the DSM-IV . . . [and less than] one-quarter felt that strong scientific evidence supported their validity" (p. 407).

To expand the study in 1998-1999, Lalonde et al. (2001) conducted a second similar study at McLean Hospital, but this time they surveyed Canadian psychiatrists (N=550). The researchers "wished to compare an approximately equal number of French- and English-speaking psychiatrists within Canada" (p. 408). The questionnaires in the two studies differed only by asking respondents in the Canadian study to identify the principal language used at work, either English or French since 25% were from Quebec

where French is the predominant language. In both studies "The questionnaire asked for respondent's theoretical orientation, authorship on published papers, and principal professional activities, ranked by time spent" (p. 498). "Those [psychiatrists] who listed two or more [theoretical] orientations or activities were classified under other" (p. 498). Additionally, the remaining four questions inquired about "their opinions regarding the diagnostic status and scientific validity of dissociative amnesia and dissociative identity disorder" (p. 408).

The results of the both surveys (Lalonde et al., 2001), which were combined when it was determined that there was little difference between the two language groups, reveal that Canadian psychiatrists were

> Significantly less accepting of the inclusion of dissociative identity disorder in the DSM-IV ($P = 0.003$) and of the scientific evidence for the validity of dissociative amnesia ($P = 0.003$) and of dissociative identity disorder ($P = 0.006$). . . . Other comparisons showed, as predicted, that psychodynamically oriented psychiatrists were more accepting than were biologically oriented psychiatrists of the nosologic status of dissociative amnesia ($P = 0.02$) and the validity of dissociative identity disorder ($P = <0.001$). (p. 410)

Other studies of mental health clinicians that asked different questions have found a range of attitudes toward dissociative disorders as noted by Lalonde et al (2001). For example, Mai (1995) found that 66% of psychiatrists in Ontario, Canada "believed" in the existence of "multiple personality disorders" (p. 411). Yet, Dunn, Paolo, Ryan, and Van Fleet (1994), found that "75% of psychiatrists and 83% of psychologists working in US Veterans' Administration medical centers "believed" in "multiple personality

disorder" (p. 411). And finally, Cormier and Thelen (1998) found, "79% of American psychologists thought that the statement 'multiple personality disorder should be considered a valid clinical diagnosis'" (p. 411).

Countertransference When Diagnosing Dissociative Disorders

The failure of the collective mental health profession to recognize and diagnose dissociative symptoms, especially early in a child's life is of concern. Sar (2008) posits, "when not prevented and/or treated successfully in childhood, dissociative disorders can become more complex after adolescence" (p. 4). I support Sar's belief that the dissociative disorders not only become more difficult to treat as the child ages up, but lack of appropriate treatment may lead to "more serious consequences such as substance abuse, and criminal behavior [and other disorders] in adolescence and in adulthood" (p. 4). With so much empirical research documenting the causal link between trauma and dissociative disorders, it is a dilemma that prompts the question, "Why is it that so many mental health professionals do not screen for a dissociative disorder?" In answer to the dilemma, Steinberg (1995) contends:

> The etiological connection between childhood trauma and dissociative symptomatology in turn confronts clinicians with some realities that many prefer not to inspect too closely. . . . Dealing with questions of human self-definition, however, has not been a significant aspect of most clinicians' training. . . . Because the dissociative disorders manifest as a fragmentation or dismembering of the patient's basic sense of selfhood and personal integrity, they pose questions that most clinicians tend to manage by referral to other specialists. . . . More disturbingly, the connection between childhood abuse and the dissociative

> disorders challenges clinicians to look at themselves and their own personal histories from a new potentially painful perspective. (p. xi-xii)

E. B. Carlson (1997) supports Steinberg's observation that, "most clinicians receive little if any formal training in the theory and assessment of trauma responses" (p. 19).

Moreover, it has been Briere's (1992) observation that since "the majority of adults raised in North America, regardless of gender, age, race, ethnicity, or social class, probably experienced some level of maltreatment as children" (p. xviii), this may be contributing to the therapist's avoidance of painful introspection. Furthermore, Steinberg (1995) cautions clinicians that it is a necessity for them to be able to "confront a possible tendency to impose his or her beliefs about abuse and recovery on the patient, to project his or her emotional issues on the patient or to become involved in boundary confusion with the patient" (p. xiii).

Since working with dissociative disorders is about working with selfhood and a sense of identity, Steinberg (1995) suggests that the clinician "will want to work through his or her own issues about selfhood and a sense of personal identity in order to assist patients with self-work" (p. xiii). As previously noted, clinicians also need to educate themselves about the causal link between trauma and dissociative disorders. Other issues challenging clinicians in diagnosing dissociative disorders include the professional's own tendencies toward self-protective incredulity. Goodwin (1985) points out:

> Like the dissociative defenses, incredulity is an effective way to gain distance from terrifying realities. Thus, Physicians can be counted on to routinely disbelieve child abuse accounts that are simply too horrible to be accepted without threatening their own emotional homeostasis. . . . Incredulity also shields the

> physician from powerful anger and rage in these families. . . . Incredulity functions, as well, to combat more subtle anxiety, allowing the physician to believe that the patient and family are not as ill as they seem. (pp. 7-8)

Furthermore, Steinberg (1995) asserts, "incredulity protects the clinician from coming to grips with her or his own professional memories" (p, 5). While empathic over-identification with a patient can cloud professional judgment, Steinberg contends, "it is also important to remember that dissociative disorders are more ordinarily subject to misdiagnosis because of the opposite form of professional overreaction" (p. 5).

Additionally, Steinberg (1995) points out Kluft's (1990c) concern that incest in particular "causes extreme countertransferential difficulties for therapists" (p. 5). Steinberg (1995) further quotes from Kluft:

> We further detoxify the impact of the patient's account by wrapping ourselves in speculations that the incest may not have occurred. The "objectivity" of the clinician who takes an incredulous stance is not objective; it is a retreat from anxiety-provoking issues and candid exploration of countertransference. (p. 33)

Several other authors have written words of caution about countertransference when treating incest survivors. Basham (2008) points out that working with trauma survivors "evokes strong feelings and alterations in one's own belief system" (p. 438). Pearlman and Saakvitne (1995) caution that we as clinicians are "vulnerable to vicarious traumatization" (p. 3). Furthermore, this insidious process, beginning at an unconscious level, may evolve into "compassion fatigue" (Figley, 1995, 2008), also referred to as "secondary stress" (Stamn, 1999) or into full blown Post Traumatic Stress Syndrome (PTSD) (Basham, 2008) with symptoms that may cloud a clinician's ethical judgment.

Therefore, it is imperative that clinicians understand what dissociation is and why dissociative symptoms evoke such strong countertransference feelings. It is equally important when working with trauma survivors that the clinician has a broad understanding of how trauma is defined by the different theoretical schools.

How Trauma is Defined: A Historical Overview

The Classical Psychoanalytic Perspective

The classical psychoanalytic view of trauma began as a direct descendant of Freud's Oedipal theory and states that even when actual prepubertal sexual traumas occur, their significance lies in the reactivation in fantasy of earlier, primarily sadomasochistically formulated exposure to primal scene experiences. For Freud and the classicists, the pathogencity of trauma derives neither from an overwhelming of the ego by unmanageable real events nor from a profound betrayal of relational bonds but, rather, from a regression to intense sadomasochistic fantasies. The pathogenic action, in other words, is considered to be intrapsychic rather than relational (Davies & Frawley 1994, p. 18). In *The Interpretation of Dreams*, Freud (1952) claimed (however, erroneously) that infantile memories, while actually encoded and stored in memory, remain unavailable for retrieval because of actively repressed, forbidden impulses and wishes. Psychoanalysis emphasized the force of forbidden wishes and ignored the continued power of overwhelming terror. Perhaps most significant for the discussion in this dissertation is that psychoanalysis dismissed the terrifying reality of the real traumatic experience and disregarded incest with statements such as "she is upset, because her Oedipal wishes came true" (van der Kolk & van der Hart, 1991, p. 435).

Then, from 1949 to 1967 came an intermediate point between Freud's thinking and contemporary proponents of the classical perspective on trauma. Phyllis Greenacre's (1949, 1952, 1967) work, like Freud's, argues that exposure to the primal scene is the prototype for all traumatogenic experience. She posits that pathology results from regression to sadomasochistic fantasies, mediated by exposure to the primal scene and potentiated by prepubertal sexual experiences. Thus it is implied that all children are exposed to the primal scene, which seems unrealistic. For Greenacre, it is the regression to fantasies belonging to a preoedipal level of psychosexual organization that is the most significant aspect of prepubertal sexual trauma; the effects of the actual traumatic events are minimized. Davies and Frawley (1994) argue against Greenacre's theory not only because it fails to incorporate the disorganizing effects of the immediate sexual abuse described, but it also appears to view the abuse as related to the fact that her patients were very "seductive" little girls and, therefore, by implication, instigating their own molestations (p. 18).

Contemporary classical psychoanalytic writers hold a slightly different view of what renders events traumatic. Davies and Frawley (1994) draw from the work of Fenichel in 1945, as well as those published forty years later by Abend (1986), Brenner (1986) and Dowling (1986) when they argue: "It is the conscious and unconscious meanings ascribed by the patient to particular events that render those events traumatic" (Davis & Frawley, p. 18). Brenner further stipulates, "The trauma, what is traumatic, is the subjective experience of the traumatized individual. It is what the event meant to the individual, which is the trauma" (p. 203).

Leonard Shengold, another contemporary classical psychoanalyst, employed the term *soul murder* in his early writings (1979, 1989) to describe child abuse. Initially, he too, subscribed to the definition of trauma as described above, but later broadened his perspective in his book *Soul Murder Revisited* (1999) stating:

> Soul murder is the term I have used for the apparently willful abuse and neglect of children by adults that are of sufficient intensity and frequency to be traumatic. By that I mean that the children's subsequent emotional development has been profoundly and predominantly negatively affected; what has happened to them has dominated their motivating unconscious fantasies; and they have become subject to the compulsion to repeat the cruelty, violence, neglect, hatred, seduction, and rape of their injurious past. (p. 1)

Shengold (1979) compared soul murder to a crime characterized by man's inhumanity to man. He views soul murder as trauma imposed from the world outside the mind that is so overwhelming that the mental apparatus is flooded with feelings. It is the terrifying "too muchness" (p. 536) that requires massive and mind distorting defensive operations in order for the child to think and feel, and threatens the child's sense of identity. As a defense, the child must not register the traumatic event, thus causing a massive isolation of feeling, confusion and denial.

In order to survive, the child needs to delusionally believe that the parent is good. Shengold describes this as a mind-splitting or mind-fragmenting operation. The child's mind is split into contradictory fragments to separate the bad from the good. Contradictory images of the self and of the parents are never permitted to coalesce; a process Shengold refers to as compartmentalization or "vertical-splitting" (1979, p. 538).

Children abused by a parent "must keep in some compartment of their minds the delusion of good parents and the delusional promise that all the terror, pain and hate will be transformed into love" (p. 538).

Shengold (1999) admits that time and age have broadened his perspective and he explains that by "soul murder" he means:

> That the children's subsequent emotional development has been profoundly and predominantly negatively affected. The trauma that these children have endured has dominated their motivating unconscious fantasies; and they have become subject to the compulsion to repeat the cruelty, violence, neglect, hatred, and rape of their injurious past. (p. 1)

The Ego Psychological Perspective

An alternative contemporary psychoanalytic perspective on trauma, as pointed out by Davies and Frawley (1994, p. 20) is ego psychology. Although it is still based on a classical metapsychological formulation, it incorporates not only the unconscious meaning of the traumatic event but also stresses the extent to which the ego is overwhelmed and rendered nonfunctional by the excessive stimulation inherent in early trauma. Proponents of the ego-psychological viewpoint include Cooper, Anna Freud, Furst, Gediman, Kramer and Akhtar, Krystal, and Levine. Indeed, when Anna Freud was tempted to call an event "traumatic," she once wrote that she needed to ask herself if the event was significant enough to alter the client's course of development; meaning that it was pathogenic (Davies & Frawley, p. 20). Furthermore, was it traumatic enough to internally disrupt the ego's functioning and ability to be a mediator? Was it catastrophic?

Krystal (1988) defines catastrophic trauma as "surrender to what is experienced as unavoidable danger of external or internal origin" (p. 154). Krystal further states:

> Evaluation of the situation as one of inevitable danger and the surrender to it, initiates the traumatic process. The affective response to the signal of avoidable danger is fear, dread, anxiety. The affective response to the perception of inevitable danger is the catatonoid reaction. (p. 154)

Another contemporary classical analyst, Howard Levine, (1990. p. 199) credits the reality of the patient's childhood as the primary factor in the development of pathological fantasies. He postulates that the analysand has a split-ego organization in which a healthier neurotic part of the personality alternates with or lies buried beneath a more impulsive, primitive part of the personality. Levine is referring to a vertical-split ego organization with a regressed neurotic part of the personality switching or alternating with a primitive part of the personality.

Davies and Frawley (1994) discuss Selma Kramer's (1990, 1991) slightly different perspective, in which she describes how patients encode memories of sexual abuse in their bodies. She contends that during classical analytic treatment the patient may reexperience the abuse as if it were happening to them all over again in the present (p. 21). In other words, they have body memories. In their book, *Splintered Reflections: Images of the Body in Trauma*, Goodwin and Attias (1999) note that the concept of body image is very complex and can be traced back to Freud. A contemporary definition of body image is provided by Fisher and Cleveland (1958) who assert:

> Body image . . . refers to the body as a psychological experience and focuses us on the individual's feelings and attitudes toward his body. It is concerned with the

> individual's subjective experiences of his body and the manner in which he or she has organized their experiences. (p. 7)

I will expand further on this concept under the object relations perspective of trauma in the next section below.

In summary, Davies and Frawley (1994) conclude:

> The ego psychologists seem to assign more weight than the classicists to the impact of real, external events on the developing ego of the child. . . . Like classical thinkers, ego-psychological clinicians pursue a primarily traditional, verbally interpretive mode of treatment with their patients. (p. 21)

In their critique of ego psychologists, Davies and Frawley (1994) contend that the ego psychologists address the extent to which unsymbolized traumatic experiences, those experiences that are encrusted in a primitive core of unspeakable terror, intrusive ideation, and somatic sensations, exist cordoned off within the patient's psyche where they are unavailable to self-reflective verbal processes and traditional analytic examination (p. 21). In my opinion, the ego psychological perspective also does not adequately address the equally important concept of dissociation and alter ego states.

The Object Relations Perspective

The object relations perspective on trauma takes into account ego incapacitation and psychic helplessness in the pathogencity of traumatic events, but mostly it stresses that early trauma signifies betrayal of the child by one or more important early objects (Freyd, 1996). This perspective, espoused by Fairbairn, 1943; M. M. Khan, 1963; Kluft, 1990a; Miller,1981; Scharff, 1982; Steele, 1986 and implied by Balint, 1979 and Winnicott, 1960 intersects with psychodynamically oriented developmentalists (Davies &

Frawley, 1994, p. 22). Bowlby (1969-1973) and D. N. Stern (1985) emphasize the primacy of early attachment bonds to significant objects. Within the object relations theoretical model, the central themes are not the magnitude of the overstimulation inherent in sexual abuse or the fantasy mediation of the traumatic event but the extent to which abusive behavior, especially by a parent, represents a psychic abandonment and profound betrayal of the child. At issue are the primacy of the child's relationship to the abusive other and the parents' failure to protect the vulnerable child from intrusive abuse. According to objects relations theory, it is the child's and, later, the adult's attempts to preserve actual and internalized relational bonds that result in symptoms, notably dissociation, and in character pathology.

Ronald Fairbairn (1943), a British Middle School object relations theorist, stressed the impact of actual relationships on a child's developing psyche. He postulated that a relationship with a bad object is not only painful for the child but also shameful. Because early object relationships are based largely on identification, children whose parents are abusive or neglectful will feel that they themselves are bad. No matter how abusive or neglectful the parents are, the child needs them and therefore cannot reject them. The internalization of bad parental objects represents, according to Fairbairn, an effort to control them. Davies and Frawley (1994) quote Fairbairn as stating,

> But, in attempting to control them in this way, he is internalizing objects which have wielded power over him in the external; and these objects retain their prestige for power over him in the inner world. In a word, he is "possessed" by them as if by evil spirits. (p. 22)

To further expand on the matter of body image and in line with the theme of object relations, we know that when a child cries out in pain, the cry normally summons the mother. It is the mother's touch, gaze, restorative holding, and mirroring that can restore the child's image of his or her body as good (Goodwin & Attias, 1999). According to Goodwin and Attias "the healing reunion of shared psychic experiences and bodily sensation restores autobiographical continuity and the intact 'good enough self (Winnicott, 1965)" (p. 227). Furthermore, Goodwin and Attias emphasis that not only can the actual pain be overwhelming, but the lack of response to the cry for help can be equally traumatic.

This dissertation will now address Bowlby's attachment theory. Although Bowlby did not specifically contribute a treatment modality to his attachment theory, contemporary trauma therapists recognize the importance of forming a secure attachment with their patients before memory work can begin. The literature also suggests, and I agree, a disorganized attachment pattern to the mother figure may be a precursor to pathological dissociative disorders. Therefore, I will present Bowlby's significant contributions prior to discussing stage-oriented trauma treatment models.

CHAPTER FOUR: THE ETIOLOGY AND CORE CONSTRUCTS OF BOWLBY'S ATTACHMENT THEORY

In this chapter we will discuss John Bowlby's attachment theory. This will include a discussion of research that led to his groundbreaking theory, the biological bases of attachment behavior and the different attachment systems. Most significantly, we will discuss the disorganized/disoriented or "D" attachment pattern believed to be an antecedent to the construction of alternative personalities as posited in this dissertation.

Bowlby's Attachment Research.

John Bowlby's attachment theory is the result of his studies of the initial naturalistic research on how young children respond to the experience of being separated from their mothers in an institutional setting, later research on young children left in a strange situation and their various behavior patterns upon reunification with their mother, and finally how the core concepts of attachment behavior contributed to a new understanding of pathological development of the personality.

During the nineteen-thirties and forties, on both sides of the Atlantic Ocean, a number of clinicians were making observations of the ill effects on personality development of prolonged institutional care and/or frequent changes of a mother figure during a child's early years of life (Bowlby, 1988, p. 20). One of these clinicians was John Bowlby, a Cambridge graduate in medicine. Bowlby was also schooled in the 1930s in the British Psychoanalytic Society, analyzed by Joan Riviere and supervised by Melanie Klein while working with child patients and utilizing object relations theory as the foundation of his thinking (Bowlby, 1969/1982, p. xxxiii). In a taped presentation, Bowlby (1984) stated:

> Object Relations theory was built into my thinking, but I was working as a child psychiatrist. I was impressed by real life situations and events that I treated. The main tradition of Object Relations has not been to do so. I was appalled by Melanie Klein's inability to pay any attention to the real life situations. Much of what I have done has been a reaction against that. (Tapes 1 & 2)

While working in an institution for boys who had been removed from their homes for stealing, Bowlby investigated 44 boys as to their early home environment and the parent-child relationships. Social workers' reports indicated that in nearly all of these cases, the boys had experienced parenting marked by parental violence and emotional abuse. In several cases a child had been blamed for a sibling's death (Kobak, 1999, p. 23).

Bowlby found similar sorts of deviant parent-child relationships in a comparison group of children at other clinics. The one factor that distinguished the thieves from the clinic children was evidence of prolonged separation from parents due to parental illness, death, or other family disruption resulting in a child being placed in foster care. His observations led him to be dissatisfied with the explanations provided by existing secondary-drive theories, primarily psychoanalytic and social learning theories, which prompted him to consider alternative explanations. His personal observations, along with the observations of others, convinced him that major disruptions in the mother-child relationship are precursors of later psychopathology (Cassidy, 1999, p. 3).

In 1950, Bowlby, then recently appointed as Chief of the World Health Organization, was asked to contribute to a United Nations study and offer advice on the mental health of homeless children (Bowlby, 1969/1982; 1973). For Bowlby, studying

actual children in real life situations was important because he regarded his research as a direct challenge to the basic tenets of Freudian theory and he had acquired a body of research data on children in the real world to support his principles of mental health (Mitchell, 1973, p. ix). The question with which he was faced, according to Mary Main (2003) was, "Why does the first three years of life seem essential to the development of mental health?" In the first part of his report in 1951, Bowlby (1969/1982) presented evidence and formulated a principle of mental health in children, positing, "What is believed to be essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother–substitute) in which both find satisfaction and enjoyment" (pp. xxvii-xxviii). In conclusion, he argued that necessary measures be taken to safeguard the mental health of children that must be separated from their families.

While Bowlby's 1951 report helped to focus attention on the problem, contribute to improved methods of care, and stimulate both controversy and research, Bowlby considered it had at least one grave limitation:

> Whereas it had much to say about the many kinds of ill effect that evidence shows can be attributed to maternal deprivation and also about practical measures that may prevent or mitigate these ill effects, it said very little about the processes whereby these ill effects are brought into being. (1969/1982, p. xxviii)

This study raised new questions for Bowlby:

> How does it come about that one or another of the events included under the general heading of maternal deprivation produces this or that form of psychiatric disturbance? What are the processes at work? Why should things happen this

> way? What are the other variables that affect outcome, and how do they affect it? On all of these issues the monograph is silent, or nearly so. . . . The reason was ignorance, mine and others. (p. xxviii)

In the mid-twentieth century experts believed that small children had basic physical needs that required tending, but emotional needs were not a consideration. The caregiver was seen as a "secondary-reinforcer," who became important to the child only by virtue of being associatively linked with physical ministrations, primarily feeding (a primary drive). And in the language of the prevailing psychoanalytic theory, the mother was, similarly, a "need-gratifying object," whose significance developed gradually through her role in satisfying drive pressures, such as hunger and warmth. Separations should not matter as long as the child's needs were taken care of (Bowlby, 1969/1982, p. xxviii).

Stephen Mitchell (1973, p. viii) tells us how Bowlby surprisingly discovered that separations and emotional needs did matter. Bowlby's attention was captured by the prospective research work of his colleague James Robertson. It was from Robertson's studies at the Hampstead Nurseries, 1948–1952, that Bowlby began to formulate his early ideas regarding attachment theory. He was impressed with the naturalistic studies of how young children behave when temporarily out of mother's care (p. xxxiii). Mitchell notes that Robertson had observed a number of young children before, during, and after a stay away from home. He found that most of these children were in their second and third years of life and not only were separated from their mothers for periods of weeks or months but were cared for in settings, such as a hospital or residential nursery, in which they had no stable mother-substitute. Further, Robertson was deeply impressed by the

intensity of the distress and misery he witnessed while the children were away from home and by the extent and duration of the disturbance that was present after they had returned home.

Additionally, Robertson found that once the child is over the age of 6 months they respond to a separation from their mother in certain typical ways with a predictable sequence of three phases of behavior, protest, despair and detachment (Bowlby, 1969/1982, p. 27). During the protest phase, the child appears acutely distressed. He will often cry loudly, shake his cot, throw himself about and look eagerly towards any sight or sound of his mother. During the phase of despair, the child's behavior suggests increasing hopelessness. He/she is physically less active, may cry monotonously or intermittently, is withdrawn and makes no demands on people or the environment. In the phase of detachment, the child seems sociable, will eat, accepts care and may even smile and play. Yet, when his mother returns there is an absence of normal behavior. Instead of greeting mother, the child acts as if the mother is a stranger, may seem apathetic and listless and turn away from her.

Following Robertson's studies were two other significant studies conducted at the Tavistock Child Development Research Unit, the first by Christopher Heinicke in 1956 and the second by Christopher Heinicke and Ilse Westheimer in 1966. In both studies the children were aged between thirteen months and three years, and the separation occurred when they were in a residential nursery. The data was treated statistically and they also described in some detail the behavior of individual children. The systematic observations of Heinicke and Westheimer confirmed the phases of protest, despair, and detachment

and made firmer the empirical base from which Bowlby worked (Bowlby, 1969/1982, p. xxxiii).

Bowlby had also been involved in a study with Robertson and Heinicke of toddlers separated from their mothers who were given good physical care. Main (2002) states:

> Nonetheless, they went through a series of unfavorable responses to the separation, first of protest in which they still hoped and called and cried to get the absent parent back. This was followed by despair, in which they were preoccupied with the absence of the parent and could not pay attention to the environment and showed a muted kind of mourning. And then detachment, in which they seemed fine again in the separation setting, but when the parent returned they actively avoided them and treated them like a stranger, and might do so for quite a period of time. (Tape # 2)

Robertson and Bowlby (1973) and his research colleagues began to see these responses as a predictable pattern that emerged in response to separation from the mother figure – one of anger and protest followed by despair and detachment. Bowlby came to wonder why the mother is so important to the child.

While there was no agreement in the psychoanalytic community at the time about the significance or relevance of these observations, Bowlby and his colleagues were confident that the observations were valid; all the evidence pointed to loss of mother figure as a dominant variable, though not the only one. Their experience suggested that, even when other circumstances were favorable, there was more distress and disturbance than was usually recognized. They held fast to the idea that the responses of protest,

despair, and detachment that typically occur when a young child aged over six months is separated from his/her mother and in the care of strangers are due to "loss of maternal care at this highly dependent, highly vulnerable stage of development" (Bowlby, 1969/1982, p. xxviii-ix). Therefore, observations of actual children suggested that maternal deprivation was extremely traumatic.

For Bowlby, the center of gravity of the data on the trauma of separation and loss of the mother figure did not match up with the center of gravity of Freud's drive theory, privileging impersonal, body-based needs and fantasies. Bowlby now believed that a new instinct theory was required in which the powerful emotional attachment between child and mother is understood not as a derivative of more basic drive processes but as fundamental in itself. This concept challenged psychoanalytic metapsychology at its core (Mitchell, 1973, p. ix).

Bowlby, however, was not working completely alone. He was in the company of other psychoanalytic contributors like Harry Stack Sullivan, W. R. D. Fairbairn, Donald Winnicott, and Hans Lowewald who became interested in his findings. But what drew so much fire in Bowlby's direction was his clarity. In contrast to the other writers, Bowlby wrote with lucidity and power identifying him as a scientist offering testable hypotheses based on data that he had collected on children in the real world to support his formulations. Indeed, his links with other scientists, especially the ethologists of his day, made his position extremely persuasive. Bowlby became much more interested than the average psychoanalyst in the correspondences between what actually goes on between people in the real world or the external environment and the neighboring discipline of ethology. Ethology, or behavioral biology, provided powerful explanatory concepts for

understanding what he had been observing in children's reactions to separation and loss lending validation and heightened interest in his observations and conclusions (Mitchell, 1973, p. ix).

This was the beginning of Bowlby's attempt to make changes to psychoanalytic theory. In the light of recent advances in biology, Ainsworth is cited by Schore (1982) as stating, "this represented a natural convergence of his two most important intellectual influences, Charles Darwin and Sigmund Freud" (p. xi).

The interweaving of concepts from ethology and psychoanalysis would help facilitate understanding of events in both the external and internal world. However, Bowlby had a slightly different point of view than Darwin and Freud. According to Schore (1982):

> Whereas both Darwin and Freud primarily (though not exclusively) focused their observational and theoretical lenses on adaptive and maladaptive functioning of fully matured adult organisms, Bowlby argued that clinical observers and experimental scientists should concentrate on still developing organisms. More specifically, he called for deeper explorations of the fundamental ontogenetic mechanisms by which an immature organism is critically shaped by its primordial relationship with a mature adult member of its species-that is, for more extensive studies of how an attachment bond forms between infant and mother. Bowlby asserted that these developmental processes are the product of the environment, and that the infant's emerging social, psychological, and biological capacities cannot be understood apart from its relationship with the mother. (p. xi)

When Bowlby first began to develop attachment theory he became aware of evidence from animal studies conducted by Lorenz in 1935 and later by Harlow in 1958 that seriously questioned whether or not the pleasure experienced by having hunger drives satisfied was associated with the mother's presence in a positive manner. This fulfillment of physiological need provided by the breast was termed the Secondary Drive by Bowlby and "cupboard-love" theory by other object relations theorists (Bowlby, 1969/1982, p. 178). In Lorenz's study, it was noted that infant geese became attached to parents that did not feed them (Bowlby, p. 165; Cassidy, 1999, p. 3). Harlow's study found that infant rhesus monkeys, in times of stress, preferred not the wire-mesh "mother" that provided food, but the cloth-covered "mother" that afforded contact comfort. When systematic observations of human infants were made, it became evident that babies, too, became attached to people who did not feed them (Bowlby, pp. 167-168; Cassidy, p. 3). Years later Bowlby (1980) recalled:

> This [secondary-drive] theory did not seem to me to fit the facts. For example, were it true, an infant of a year or two should take readily to whomever feeds him, and this clearly is not the case. But, if the secondary drive dependency theory was inadequate, what was the alternative? (p. 650)

Although Bowlby began to value ethology, primarily because it provided a wide range of new concepts concerned with the formation of intimate social bonds – such as those tying offspring to parents and parents to offspring – he also sought understanding with colleagues from such fields as evolutionary biology, developmental psychology, cognitive science and control systems theory. While Bowlby's early writings did point

out that attachment is a life-long phenomenon, this current study will focus primarily on his principle concept of the tie to the mother during childhood. In the following section we will discuss a key concept in Bowlby's theory, that of a behavioral control system.

Biological Bases of Attachment Behavior: An Evolutionary Perspective

The most fundamental aspect of attachment theory is its focus on the biological bases of attachment behavior. Cassidy (1999) writes:

> Attachment behavior has the predictable outcome of increasing proximity of the child to the attachment figure (usually the mother). Some attachment behaviors (smiling, vocalizing) are signaling behaviors that alert the mother to the child's interest in interaction, and thus serve to bring her to the child. Some (approaching and following) are active behaviors that move the child to the mother. (p. 4)

In Cassidy's (1999) introduction to attachment theory he states:

> Bowlby proposed that during the time in which humans were evolving, when humans lived in what he called "the environment of evolutionary adaptedness" genetic selection favored attachment behaviors because they increased the likelihood of child-mother proximity, which in turn increased the likelihood of protection and provided survival advantage. (p. 4)

The neo-Darwin theory developed in the 1930s by Ronald Fisher, Jack Haldane, and Sewall Wright proposed that the basic concept of the genetical theory of natural selection is that the unit central to the whole process is the individual gene and that all evolutionary change is due to the fact that certain genes increase in number over time, whereas alternative genes decrease or die out. What this means is that through the process of differential breeding successes, individuals that are carrying certain genes increase in

numbers while individuals that are carrying others diminish. In sum, the adaptedness of any particular organism requires that it not only be capable of individual survival, but that the ultimate outcome to be attained is always the reproductive survival of the genes an individual is carrying (Bowlby, 1969/1982, p. 56).

Attachment Bond Versus Attachment Behavior

Bowlby (1969/1982) postulates a clear distinction between the concepts of attachment bond and attachment behavior. The attachment bond means that the child is "strongly disposed to seek proximity to and contact with a specific figure and to do so in certain situations, notably when he is frightened, tired or ill" (p. 371). Attachment behavior, by contrast, refers to any of the various forms of behavior that a child commonly engages in to attain and/or maintain a desired proximity to some differentiated and preferred individual. Bowlby notes attachment behavior is episodic, "At any one time some form of such behavior may be either present or absent and which it is to a high degree, dependent on the conditions obtaining at the time" (pp. 372-373).

Bowlby (1969/1982) further proposed that the child's attachment behavior is controlled by a behavioral system conceived as an organization existing within the child. The system is equipped with sensors that monitor and appraise events that fall into two classes: those that indicate potential danger or stress, both internal and external, and those concerned with the whereabouts and accessibility of the attachment figure. When the child's appraisal of the condition causes him/her to feel uneasy, unwell or insecure, anxious or even terrified, the behavioral action is to seek proximity to the attachment figure. The particular action will vary according to what is a suitable response to the condition and will continue until the child feels comfortable and secure (p. 373).

As a class of behavior with its own dynamic, attachment behavior is conceived as distinct from feeding behavior and sexual behavior and of at least an equal significance in human life. During the course of healthy development, attachment behavior leads to the development of affectional bonds or attachments, initially between child and adult and later between adult and adult. The forms of behavior and the bonds to which they lead are present and active throughout the life cycle.

Behavioral System

Many authors believe that attachment behaviors are organized into an "attachment behavioral system" (Cassidy, 1999, p. 5). Cassidy notes, "The concept is borrowed from ethology to describe a species-specific system of behaviors that leads to certain predictable outcomes, at least one of which contributes to reproductive fitness. The concept of the behavioral system involves inherent motivation, not 'drive'" (p. 5). Research findings that infants become attached even to abusive mothers suggest, according to Bowlby, that simple pleasurable associations do not drive the system. Indeed, the organization of various attachment behaviors that are found to be the most useful to the individual in the moment in response to both internal and external cues is the central concept of the attachment behavioral system (Cassidy, p. 5).

> Thus an infant may maintain a stable internal organization of the attachment behavioral system in relation to the mother over time and across contexts, yet the specific behaviors used in the service of this organization may vary greatly as the child develops and gains access to a greater variety of ways of achieving proximity. (p. 5)

Bowlby (1980) states:

> So long as the attachment figure remains accessible and responsive the behavior may consist of little more than checking by eye or ear on the whereabouts of the (mother) figure and exchanging occasional glances and greetings. In certain circumstances, however, following or clinging to the attachment figure may occur and also calling or crying, which are likely to elicit his or her caregiving. (p. 39)

Regarding the manner in which a child accomplishes contact with the attachment figure, Bowlby (1969/1982) states, "Whether a child moves toward a mother by running, walking, crawling, shuffling, or in the case of a thalidomide child, by rolling, is of very little consequence compared to the set-goal of his locomotion, namely proximity to mother" (p. 373). Sroufe and Waters (1977) emphasize that the attachment behavioral system is "not a set of behaviors that are constantly and uniformly operative" (p. 1185).

Bowlby (1980, p. 40) proposes that whereas an attachment bond endures, the various forms of attachment behavior that contribute to it are active only when required. Thus, the systems mediating attachment behavior are activated only by certain conditions, for example, strangeness, fatigue, anything frightening, and unavailability or unresponsiveness of an attachment figure. Likewise, they are terminated only by certain other conditions, for example, a familiar environment and the ready availability and responsiveness of an attachment figure. However, when attachment behavior is strongly aroused, termination may require touching, clinging or the actively reassuring behavior of the attachment figure. According to Bowlby, many of the most intense emotions arise during the formation, the maintenance, the disruption, and the renewal of attachment relationships. Just as all-important relationships are affected by the dynamics of

attachment processes, so will the therapeutic relationship be affected by the dynamics of the attachment process.

Slade (1999) contends the patient's attachment organization and attachment history will have a profound effect on the patient's feelings about the clinician as well as his or her conscious and unconscious expectations of the clinician. In turn, attachment dynamics will also influence the clinician's feelings in response to the patient. From an attachment perspective, successful treatment involves a patient's capacity to "contemplate and indeed reexperience his or her life story within a safe and healing context with an emotionally available and sensitive other" (p. 586). Furthermore, the degree to which the patient can join with the therapist to co-create a new sense of self and relationship "is a function of the patient's attachment security" (p. 587). Patients "with insecure attachment histories are likely to have 'transferential expectations' that the therapist will not understand, will not be available, or will in some way violate the patient's sense of safety and security" (p. 587). And as might be expected, a client's response to treatment will emerge according to their attachment organization. An example is a client I treated who told me in the first session that everyone in her life had abandoned her, including her last therapist, and she stated, "You, too, will abandon me."

Just as important as the client's transferential expectations are the countertransference reactions evoked in the clinician. A clinician with an insecure attachment history will bring personal insecure representational models into the therapeutic relationship. Slade (1999, p. 588) contends that "the therapist can experience themselves [*sic*] caught in the same barren landscape as the patient . . . feeling much as the patient once felt as a child; angry, unacknowledged, silly and inept" (p. 588).

Goal-Corrected Homeostatic Behavioral System

Attachment behavior, like other forms of instinctive behavior, is mediated by behavioral systems, which early in development become goal-corrected. Unlike certain reflexes that, once activated, maintain a fixed course (e.g., sneezing, rooting), the attachment behavioral system enables the individual to respond flexibly to environmental changes while attempting to attain the goal of maintaining certain degrees of proximity to, or of communication with, the discriminated attachment figure (Cassidy, 1999, p. 5).

Borrowing from control theory, Bowlby (1982) described the goal-corrected behavioral system as a regulator or homeostatic system that is capable of effective operation only when the environmental conditions relevant to its operation remain within certain limits. When they do not, the system becomes overstretched and eventually fails. Borrowing an example from physiology, Bowlby asserts that the system is responsible for keeping the body temperature close to the norm. So long as the ambient temperature remains within certain upper and lower limits it operates effectively. But, when the ambient temperature stays either above or below these limits for a sufficient length of time, the system is unable to function as efficiently and achieve its goal. As a result the body temperature rises or falls, and the organism suffers from hyper- or hypothermia. The environmental conditions that produce these physiological states are termed stressors; the states themselves are states of stress, while the personal experience is one of distress (Bowlby, 1980, p. 42). Like physiological control systems, Bowlby (1969/1982) believed a behavioral control system to be organized in the central nervous system (p. 372). In other words, systems of this type are so structured that by means of feedback

continuous account is taken of any discrepancies there may be between initial instruction and current performance so that behavior becomes modified accordingly.

Since the goal of attachment behavior is to maintain an affectional bond, any situation that seems to be endangering the bond elicits action designed to preserve it; and the greater the danger of loss appears to be the more intense and varied are the actions elicited to prevent it. In such circumstances all the most powerful forms of attachment behavior become activated – clinging, crying, and perhaps angry coercion. This is the phase of protest and one of acute physiological stress and emotional distress. When these actions are successful, the bond is restored: the activities cease, and the states of stress and distress are alleviated (Bowlby, 1980, p. 42).

When, however, the effort to restore the bond is not successful, sooner or later the effort wanes, but usually does not cease. The person's attachment behavior remains constantly primed, and under certain conditions, becomes reactivated. The condition of the organism is one of chronic stress. At intervals, both stress and distress are likely again to become acute. In Bowlby's view, attachment behavior stops in the presence of a terminating stimulus. For most distressed infants, contact with the mother is a terminating stimulus. The infant is viewed as using the mother as a "safe haven" to return to in times of trouble (Cassidy, 1999, p. 6).

Bowlby (1980), paraphrasing Engle's analogies of the loss of a loved person states:

> [The] loss of a loved person is as traumatic psychologically as being severely wounded or burned is physiologically. Invoking homeostatic principles, Engle further states: "The experience of uncomplicated grief represents a manifest and

> gross departure from the dynamic state considered representative of health and well-being. . . . It involves suffering and an impairment of the capacity to function, which may last for days, weeks, or even months." (p. 42)

Bowlby (1980) further writes,

> The processes of mourning can thus be likened to the healing that follows a severe wound or burn. It may take a course in time that leads to a full, or nearly full, function being restored; or they may take one of many courses with an outcome of various impairments in function. (p. 43)

The Role of Emotion

According to Bowlby (1973), there were two main conclusions drawn from Robertson's early studies. The first conclusion was that "the sequence of *intense* protest, followed by despair and detachment" (p. 22) includes a combination of factors, including strange people, strange events, and the absence of mothering. The second conclusion was that "separation from the mother figure is in itself a key variable in determining a child's emotional state and behavior" (p. 22). The words "separation" and "loss" were defined to always imply that the subject's attachment figure is inaccessible, either temporarily (separation) or permanently (loss). Bowlby (1979) further states:

> Emotions are strongly associated with attachment. . . . Many of the most intense emotions arise during the formation, the maintenance, the disruption, and the renewal of attachment relationships. The formation of a bond is described as falling in love, maintaining a bond as loving someone, and losing a partner as grieving over someone. Similarly, threat of loss gives rise to sorrow, whilst each

> of these situations is likely to arouse anger. The unchallenged maintenance of a bond is experienced as a source of joy. (p. 130)

In contrast, Freud's earliest writings from 1894 did not recognize that anxiety arises from loss or the threat of loss, or that defensive processes are evoked in conditions of intense anxiety. In his later writings, however, he did address these issues: the one paragraph included in the *Three Essays on the Theory of Sexuality* (1905) was expanded to three pages in the *Introductory Lectures* (1917). It was not until 1926 in his revolutionary work *Inhibitions, Symptoms and Anxiety* that Freud accorded it the central place in what was to be his final theory of anxiety. Unfortunately, Freud's ideas on separation anxiety and its relation to mourning came too late. By 1926 a substantial corpus of psychoanalytic theory was already being taught. For example, anxiety, castration anxiety, and superego anxiety were the cornerstones of thought and practice in Vienna and elsewhere by Freud's followers, who included Kris. A different theory was hypothesized by Melanie Klein, relating anxiety to aggression and linking it to the concept of the death instinct, which would become a key concept in a significant new system. Bowlby (1973), in quoting from a paper written by Kris (1950) that reflects on his participation in the psychoanalytic school in Vienna states, "Nobody realized that the fear of losing the object and the object's love were formulae to be implemented by material, which now seems self evident beyond any discussion" (p. 29).

The Role of Cognition

Bowlby (1969/1982), also interested in cognitive information theory, proposed that the attachment behavioral system allowed the human species the capacity to build up

a detailed representation of the world in which he lives, a topic researched by Piaget. Bowlby stated:

> The achievement of any set goal, then, requires that an animal is equipped so that it is able to perceive certain special parts of the environment and to use that knowledge to build up a map of the environment, that, whether it be primitive or sophisticated, can predict events relevant to any of its set-goals with a reasonable degree of reliability. (p. 49)

Along with mental representations of the environment, Bowlby (1969/1982) proposed that the attachment behavioral system also included mental representations of the attachment figure and the self all largely based on real experiences. Whereas Freud emphasized the role of internal fantasies, Bowlby referred to these representations as "representational models" and as "internal working models" (p. 354). According to Bowlby, these models allow individuals to anticipate the future and make plans, thereby operating most efficiently. The child is thought to rely on these models, for instance, when making decisions about which attachment behavior(s) to use in a specific situation with a specific person.

Bowlby (1969/1982) further stated:

> [A] behavioural [*sic*] system responsible for goal-corrected behavior is more complex and has two vital components: (a) a means of receiving and storing instructions regarding the set-goal, and (b) a means of comparing the effects of performance with instruction and changing performance to fit. (p. 70)

It is supposed that the instructions come to exist within it as a result of its development within a particular environment and is the result of the animal's genetic endowment

interacting with the environment. Additionally, the animal needs access to a reasonably accurate cognitive map of its environment to help it finds its way quickly to safety.

There were also other cognitive processes discussed by Bowlby within the attachment system including "object permanence, discrimination learning, non-conscious processing, selective attention and memory, and interpretative biases" (Cassidy, 1999, p. 7) that are beyond the scope of this paper. An extensive discussion is provided elsewhere (e.g., Bretherton & Munholland, 1999; Main, Kaplan, & Cassidy 1985; Baldwin 1992).

Attachment in Relations to Other Behavioral Systems

Cassidy (1999) informs us that to comprehend the attachment behavioral system we must understand "its complex interplay with other biological based behavioral systems. . . . Two of these systems related to the attachment system in young children are the exploratory behavioral system and the fear behavioral system" (p. 7). Whereas Bowlby's original writings referred to activation of an alarm system with a fear response, contemporary authors simply refer to a "fear" behavioral system. According to Cassidy: "Activation of the fear system generally heightens activation of the attachment system. In contrast, activation of the exploratory system can, under certain circumstances, reduce activation of the attachment system" (p. 7).

Attachment Systems

The Exploratory System

Cassidy (1999), describing Bowlby's exploratory systems, writes, "the exploratory system gives survival advantage to the child by providing important information about the workings of the environment: how to use tools, build structures,

obtain food, and negotiate physical obstacles. Yet, unbridled exploration with no attention to potential hazards can be dangerous" (pp. 7-8). Notable contributions in understanding the exploratory system were made by Bowlby's colleagues working in the sciences of ethology and developmental psychology. One example is from the work of Mary Salter Ainsworth formerly of Johns Hopkins University. Ainsworth, who initially trained as a developmental psychologist, worked with Bowlby in the 1950s at the Tavistock Clinic. Subsequently, she pioneered empirical studies of attachment behavior in both Uganda in Africa, and in Baltimore in the USA. Her work along with that of her students was regarded as "the best-supported theory of socio-emotional development available at that time" (Bowlby, 1988, p. 28).

During her studies of mothers and infants in Uganda, Ainsworth (1967) was struck with how infants, once mobile, commonly use mother as a base from which to explore. When conditions are favorable, an infant moves away from mother on exploratory excursions and returns to her again from time to time. By eight months of age, almost every infant in Ainsworth's Uganda study had a stable mother figure to whom they had become attached and demonstrated this behavior. However, when mother was absent, the exploratory behavior was less evident or ceased. The concept was developed by Ainsworth that an ordinary devoted mother provides the infant with a "secure base" from which he can explore and to which he can return when frightened or upset. Bowlby (1988) came to regard Ainsworth's concept of a secure base as crucial for understanding how an emotionally stable person develops and functions "*all through his life*" [italics in original] (p. 46).

In her Baltimore study, Ainsworth (1967) was able to expand the information learned in Uganda and described many individual variations seen in a sample of twenty-three infants at 12 months of age. The study observed mothers and infants interacting in the natural environment of their home and also when they were placed in a slightly strange test situation. Following the two studies, Ainsworth proposed a hypothesis linking certain types of emotional and behavioral development at 12 months with certain types of preceding mothering experience.

Drawing on observations of behavior in both types of situation, Bowlby (1988) tells us that Ainsworth was able to classify the infants into three main groups according to two criteria: (a) how much or how little they explore when with mother or without her, and (b) how they treat mother when she is present, when she departs, and especially, when she returns. The first group, eight children, labeled group X as described by Ainsworth:

> explored actively, especially in mother's presence, used mother as a base by keeping note of her whereabouts, exchanging glances, and from time to time returning to her to share in enjoyable mutual contact. When mother had been absent for a short time she was greeted warmly on her return. (p. 47)

This group was given a positive prognosis for the future.

> The second group of eleven children, Ainsworth called group Y:
>
> explored little and instead sucked a thumbs or rocked. Constantly anxious about mother's whereabouts, they cried much in her absence, but were contrary and difficult upon her return. . . . [Others] in this group alternated between appearing very independent and ignoring mother altogether, and then suddenly becoming

> anxious and trying to find her. Yet, when they did find her, they seemed not to enjoy contact with her, and often struggled to get away again. (p. 47)

This group presented a classical picture of ambivalence and their prognosis was given cause for concern. The third group with the remaining four children, group Z, "were judged to occupy an intermediate position between those given a good prognosis on their first birthday and those given a guarded one" (p. 47). The researchers in the Baltimore study recorded the infant and mother's behavior using a nine point rating scale measuring the degree of sensitivity or insensitivity that a mother shows to her baby's signals and communications. Whereas a sensitive mother is likely to interpret the signals correctively and respond appropriately, an insensitive mother will often not notice her baby's signals or misinterpret them or respond tardily or inappropriately (p. 48).

Bowlby (1988) summarized Ainsworth's original in-home observations of the *strange situation* noting that it had established key differences among mothers of secure, avoidant, and ambivalent infants with respect to four highly intercorrelated variables: sensitivity (defined as prompt and appropriate responsiveness to the infant's signals), acceptance (vs. rejection), cooperation, and psychological accessibility. Ainsworth's findings of a correlation between a mother's responsiveness to her infant and the infant's way of behaving towards her at 12 months is highly significant statistically and has been confirmed by subsequent studies (p. 48).

Bowlby (1973) further asserted that infants or young children subjected to experiences of insensitive mothering, mixed with occasions of outright rejection, and later to separations or threats of separation greatly increase a child's fear of losing his mother, increase his demands of her presence and also his anger at her absences, and may

also lead him/or her to despair of ever having a secure and loving relationship with anyone. This expectation then becomes the internal working model of his or her self. According to Bowlby (1973):

> In the working model of the world that anyone builds, a key feature is his notion of who his attachment figures are, where they may be found, and how they may be expected to respond. Similarly, in the working model of the self that anyone builds a key feature is his notion of how acceptable or unacceptable he himself is in the eyes of his attachment figures. On the structure of these complimentary models are based that person's forecasts of how accessible and responsive his attachment figures are likely to be should he turn to them for support. And in terms of the theory now advanced, it is on the structure of those models that depends, also, whether he feels confident that his attachment figures are in general readily available or whether he is more or less afraid that they will not be available occasionally, frequently or most of the time. (p. 203)

Conversely, Solomon and George (1999) assert:

> A working model of self as devalued and incompetent is the counterpart of a working model of parents rejecting or ignoring of attachment behavior and/interfering with exploration. Thus the developing complementary models of self and parents . . . represent both sides of the relationship. (p. 91)

Disorganized Attachment or Category "D"

Ainsworth's original attachment relationship classification system identified only three main classification groups: (a) a "secure" group, (b) an insecure "avoidant" group and, (c) an insecure "ambivalent" group (Solomon & George, 1999, p. 290). These

classifications were based on the infant's behavior toward the mother or caregiver upon reunion after a separation. Subsequent research by Main and Solomon (1986, 1990), found that about 15% of attachments in normative samples were difficult to classify using Ainsworth's original three categories. In high-risk samples of the infants, the percentages would be expected to be even higher. Main and Solomon's (1990) observations of infants' behavior were found to be "unclassifiable" using Ainsworth's model and, therefore they developed a fourth classification group termed, "D" "disorganized/disoriented" (p. 290).

Solomon and George (1999) found that infants in the strange situation categorized as disorganized/disoriented, or D infants, demonstrated a "(1) freezing, stilling, and slowed movements and expressions . . . (2) sequential display of contradictory behaviour [*sic*] patterns . . . (3) simultaneous display of contradictory behavior patterns...and (4) undirected, misdirected, incomplete, or interrupted movements and expressions" (p. 11). Solomon and George argue that it is clear that Ainsworth and Bowlby did not differentiate what is now called "disorganized" behavior from other more coherent patterns of "insecure avoidant" or "insecure ambivalent" behavior.

Solomon and George (1999), in agreement with Bowlby, further contend that while prolonged separations under adverse circumstances may result in failure to terminate attachment behavior, there are other parental behaviors that might have a similar result, including "strong parental rejection of the child's attachment behavior and direct or implied threats by the parents to abandon or send the child away" (p. 12). For example, a client in my practice who had been adopted was frequently threatened by his adoptive mother to be sent to an orphanage for bad behavior. In fact, his mother would

put on her hat coat and act as if she was leaving the house to intentionally frighten him. Indeed, the mother's behavior activated the child's attachment system, yet, prevented the child from achieving resolution. Solomon and George paraphrase Bowlby's proposed theory stating that "both anxiety (fear) and anger are segregated because their display would likely alienate the attachment figure still further" (p. 12). While Bowlby did not specifically mention child physical abuse or sexual abuse in his original work, it was established by E. A. Carlson, Cicchetti, Barnett, and Braunwald in 1980, as reported by Solomon and George, that 80% of infants categorized as having disorganized D attachments have been maltreated (p. 12).

Bowlby (1973) further stated that there seems little doubt that when infants and little children are the subjects of insensitive mothering, mixed with occasions of outright rejection, and later to separations and threats of separation the effects are deplorable. Such experiences greatly increase a child's fear of losing his mother, increase his demands of her presence and also his anger at her absences, and may also lead him to despair of ever having a secure and loving relationship with anyone.

The Alarm System

Many authors believe that the "alarm system" or fear behavioral system is linked to the attachment system. For Bowlby, the biological function of the alarm system, like that of the attachment system, is protection. Bowlby described "natural clues to danger," stimuli that are not inherently dangerous but increase the likelihood of danger. These include darkness, loud noises, heights, aloneness, and sudden looming movements. Infants who are frightened increase their attachment behavior seeking protection from their attachment figure (Cassidy, 1999; Kobak, 1999).

In addition to a natural set of clues to danger are a variety of cultural clues that are learned through observation or association. For example, van Ijzendoorn and Sagi (1999) contend, "if a cultural niche requires the suppression of emotions, infants may develop an avoidant attachment to meet this cultural demand" (p. 714). Bowlby (1973), noted that the fear system is most likely to be activated in "compound" fear situations, in which more than one clue to danger is present. The goal of various fear behaviors such as avoidance, withdrawal, and attack is to increase the distance to the feared object or eliminate it. If the attachment figure is not available the child faces a compound fear situation: Not only is the child facing danger, but also the child is cut off from a critical source of protection. According to Kobak (1999), "Bowlby sought to reserve the term 'fear' for situations that alarm a child as the result of frightening stimuli, and the term 'anxiety' for situations in which an attachment figure is absent" (p. 26). Kobak summarizes the work of Bowlby and Robertson suggesting that the children placed in residential nurseries and hospitals experienced alarm or fear due to placement in an unfamiliar setting and being cared for by strangers, as well as anxiety when they were unable to access to their mothers.

The Sociable System

Bowlby did not discuss the sociable or "affiliative" behavioral system as extensively as he did other systems. He did, however, point out that the sociable system is distinct from the attachment system. According to Cassidy (1999, p. 9), the sociable system is defined as the organization of the biologically based survival-promoting tendency to be sociable with others. An important predictable outcome of activation of this system is that individuals in the company of others are much less likely to be killed

by predators. The sociable system is likely to contribute to the individual's survival and reproductive fitness in other important ways. Primates biologically predisposed to be sociable with others increase their ability to gather food, build shelter, and create warmth; they learn about the environment more efficiently; and they gain access to a group of others with whom they may eventually mate.

Social competence is clearly an important task of development. According to Weinfield, Sroufe, Egeland and Carlson (1999), "competence in general is defined by two capacities: (a) being able to make use of the environment, and (b) being able to make use of personal resources in order to achieve a good developmental outcome" (p. 81). Navigating the world of social relationships is especially important. Attachment relationships influence what a person will expect in later relationships. Secure infants as they develop will expect social partners to be responsive to them. Anxious infants as they develop will expect to be treated inconsistently or rejected by social partners and will believe that they are not worthy of better treatment (Bowlby, 1969/1982). Another way in which the attachment relationship influences social competence is through teaching the infant about behavioral synchrony and communication. The sensitive, responsive behavior of the caregiver in a secure dyad teaches the secure infant that communication is contingent upon each partner's cues and responses. All infants carry with them the expectations of how they should respond to social partners, and how social partners are likely to respond to them (Weinfield et al.,1999). Beginning in infancy and continuing throughout the life course an individual's mental health is seen as intimately tied to relationships with attachment figures that afford emotional support and protection, (Bretherton & Munholland, 1999).

Weinfield et al. (1999) further postulates that the data on social competence illustrates the continuity between early attachment differences and later functioning. A study by Pastor (1981) found differences in orientation toward peers as early as during the toddler period. In preschool the child's adaptive capacity expands as they begin to function with some proficiency in a group. Furthermore, Sroufe (1983) found that teachers rated children with secure histories as more competent in their engagement with peers in a group setting.

During the period of middle childhood, starting at age five years, and prior to adolescence, social competencies for the child become more complex. Weinfield et al. (1999) contend that the child's developmental tasks, in addition to simply interacting with others, includes developing personal relationships with others that will sustain over time, finding their place in the more organized peer group (i.e. their classmates), and coordinating friendships with group functioning (i.e. an athletic team). Again, Sroufe's 1983 study confirmed teacher's ratings of greater interpersonal competence among children with secure histories.

In yet another study Elicker, Englund, and Sroufe (1992) found that children with secure histories, compared to those with anxious histories, more often formed friendships at a summer camp. Sroufe, Bennett, Englund, Urban, and Shulman (1993) found that adolescents with secure histories were more socially competent in a mixed-gender crowd in particular. Additionally, those with secure histories were better able to maintain appropriate boundaries with the opposite sex.

In sum, in all of the above-mentioned studies, social competence assessments at each age were predicted by earlier assessments of competence and were predictive of

competence at later stages. The research thus supports what Bowlby's developmental theory would predict, attachment history, along with earlier social competence, predicts later social competence. Unfortunately, social competence is impaired and the ability to form secure attachments with others is compromised when the infant develops an insecure disorganized attachment.

Attachment and Pathological Development in Childhood

Research studies of Bowlby's attachment theory and psychopathology over the last 15 years have contributed immensely to the understanding of childhood disorders beyond infancy. According to Greenberg (1999):

> Numerous empirical findings indicate that the development of a secure attachment with caregiver(s) in the first 2 years of life is related to higher sociability with other adults and children, higher compliance with parents, and more effective emotional regulation. . . . Moreover, insecure attachment prior to age 2 has been related to lower sociability, poorer peer relations, symptoms of anger, and poorer behavioral self-control during the preschool years and beyond . . . all potential factors in the development of childhood psychopathology. (p. 469)

According to Greenberg (1999), there are two general ways by which attachment theory and research may inform the study of childhood psychopathology. First, atypical attachment patterns in early childhood may be considered early disorders. Second, the type of attachment pattern may contribute to later disorders by either increasing risk or buffering the effects of risks.

In fact, for many years following publications by Bowlby and other researchers on attachment theory that date back to the 1950s, clinicians of various disciplines and in

various fields, including psychiatry, pediatrics, and social work were well aware of the importance of early attachment, and they hypothesized that children's impairments in cognition, behavior, and affect were a result of either deprivations or disruptions in attachment relationships. However, it was not until 1980 in the 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) that attachment disorders were recognized and termed "reactive attachment disorder" (Greenberg, 1999, p. 470). It was characterized as a disorder that needed to occur before eight months of age and was marked by a pervasive disturbance across all relationships in spite of the fact that there was little to no association to attachment. Instead, the disorder was related to "failure to thrive." In the revision of *DSM-III-R* (1987), the criteria was changed and the age of onset became five years of age or younger, and the criteria, "failure to thrive" was dropped. In 1994, additional nosological revisions were made to the *DSM-III-R* and the age criteria were changed to zero to three, which includes a specific axis of parent-child relationship disorders and a global assessment scale of parent-child relationships. The types of relationship disorders included were "over-involved," "under-involved," abusive," "angry/hostile," "anxious/tense," and "mixed" (Greenberg, p. 470).

More contemporary research, beyond that of Main and Solomon (1986, 1990), has contributed to identifying the central issue in distinguishing insecure attachments. Zeanah, Mammen, and Lieberman (1993) argue that insecure attachments are distinguished by the degree to which emotions and behaviors indicate profound disturbances in the child's feeling of safety and lead to risk for persistent distress or disability.

Research has shown that risk factors for childhood disorders have led to seven general conclusions. First, development is complex and most likely can be attributed to more than one risk factor. Thus, Sroufe (1983) contends it is doubtful that attachment insecurity alone will lead to a disorder.

Second, different combinations of risk factors may lead to the same disorder. In the single most common childhood mental disorder, no single cause may be either necessary or sufficient (Greenberg, Speltz, & De-Klyen, 1993).

Third, risk factors occur not only at the individual and family level, but also at the level of the peer group, the neighborhood, and between the family and social institutions. In other words, risk also occurs at a macro level.

Fourth, there appears to be a nonlinear relationship between risk factors and outcomes. Although one or two risk factors may show little prediction to poor outcomes, there appears to be a rapid increase in the rate of disorders when additional risk factors are added (Greenberg, 1999, p. 473).

Fifth, many developmental risk factors are not disorder-specific. The combination of poverty, family violence, and parental psychopathology has been associated with a variety of childhood disorders. Risk factors predict multiple outcomes, often with overlap between problem behaviors. For example, attachment has been considered a risk factor for both internalizing and externalizing disorders (Greenberg, 1999, p. 473; E. A. Carlson & Sroufe, 1995).

A sixth guiding principle is that certain risk factors may have differential influence at different developmental periods. For example, during early childhood development, secure attachment may be more important than during middle childhood,

whereas, during middle childhood cognitive ability and motivation may be more important. And, during adolescence, parental norms regarding behavior may be the most critical factor. Children who are securely attached during the first few years of life may be more resilient to traumatic situations in later childhood (Greenberg, 1999, p. 473). And seventh, risk factors may vary with the added influence of gender, ethnicity, and family atmosphere factors.

Some authors suggest that there is a possible connection between early trance-like states as seen in the disorganized attachment of infants and later dissociative disorders. Dozier, Chase, and Albus (1999) highlight Perry, Pollard, Blakely, Baker, and Vigilante's (1995) argument that evolution has predisposed infants and children to experience dissociative states as a defense in the face of threat. Children who could not fight or flee in the face of danger might have a better chance of survival in a dissociative state. Further, when children repetitively experience dissociative states they become sensitized and their neural networks become compromised. Dozier et al. point out that these children are especially vulnerable if they are developmentally "undergoing critical periods of the organization of brain systems. . . . The child who repeatedly enters dissociative states will more readily enter such states under conditions of mild stress" (p. 506). Furthermore, if a child is experiencing fright from a primary caregiver or attachment figure, and there is no one to turn to for comfort and protection, the child is put in a position of experiencing "fright without solution" (Main & Hesse, 1990).

In contrast, dissociation has also been found to occur when the child frightens the mother figure. Examples of a frightened mother figure might include one who is experiencing a psychiatric illness such as severe depression, and is unable to soothe a

crying baby; one who is frightened due to a domestic violence situation, a natural disaster, or a severe accident; and one who is experiencing dissociative identity disorder and switches to a child alter who may fear the infant/child's protest cry. A frightened mother figure contributes to a disorganized attachment pattern. Wieland (2011), drawing from Liotti (1999a, 2009) writes, "not only can the child not rely on the adult for support, but may experience themselves as the cause of the parent's distress" (p. 11). Further, Dozier et al, (1999) drawing from Main and Hesse (1990) write:

> Thus, the child develops multiple, incompatible models of self and the other. In interactions with the caregiver the child experiences rapid shifts in which the caregiver is at first frightened, then no longer frightened, then caring for the child. With each shift, a different model of self (perpetrator of fright, rescuer, loved child) and of caregiver (victim, rescued victim, competent caregiver) is operative. (p. 506)

In summary, following the proposed theory of Perry, Blakley, Baker, and Vigilante (1995), Dozier et al. (1999) conclude, "The experience of dissociative states in childhood leads to a sensitized neurobiology that predisposes individuals to experiencing later dissociative states" (p. 506). Dozier et al., drawing from E. A. Carlson (1998), further posit that disorganized attachment in infancy and childhood experiences of abuse, especially fright without solution, "may predispose individuals to dissociative states in adulthood" (p. 506). Advances have been made in attachment theory regarding the process of transmission and understanding the various pathways that lead to developmental psychopathology in children.

Psychopathology in Adulthood

The quality of the infant's attachment to his or her primary attachment figure and subsequent attachment-related experiences (trauma, fright without solution, separation, loss) might be related to risk for psychopathology across the lifespan into adulthood. The working models of the self and self in relation to other that infants develop shape their expectations of how others will treat them in a relationship. Dozier et al. (1999, p. 498) assert that the evidence specifically linking infants' attachment behavioral strategies to adult psychopathology is limited to two studies reporting data from the Minnesota Parent – Child Project's longitudinal sample. More research is warranted. While it is beyond the scope of this paper to delve deeply into the etiology of the many adult diagnostic categories linked to traumatic attachments, I refer the reader to Jon Allen's book, *Traumatic Relationships and Serious Mental Disorders* (2001), for a broader understanding; however, I will focus specifically on the diagnostic category that is the focus of this study: Dissociative Disorders.

Positive Protective Factors

In contrast to risk factors, there are mediating protective factors. These include the characteristics of the individual (i.e., temperament, intelligence), the quality of the child's relationships, and ecological factors such as schools, neighborhoods, and laws and regulations that protect children (Greenberg, 1999, p. 473).

CHAPTER FIVE: TRAUMA TREATMENT MODELS FOR DDNOS AND DID

Spira's Treatment Principles

Treatment for DID and DDNOS occurs in various formats, including inpatient hospital-based therapy, outpatient therapy, and medication supported therapy. For each treatment modality, certain principles apply, which are well established in the trauma literature. One set of principles is offered by Spira (1996):

> (1) developing immediate rapport, (2) gathering critical information about the origin of the disorder, along with subsequent successes and failures in psychosocial functioning, (3) communicating effectively with all of the alters, (4) establishing an interpersonal therapeutic relationship, (5) respecting the patient's existential motivation, (6) using cognitive-behavioral therapy (CBT) to assist in coping with current stressful situations, and (7) using hypnosis, which can greatly facilitate the treatment of the patient with DID. . . .
>
> Persons with DID are extremely interpersonally sensitive and need lots of reassurance that they are understood and cared about. [Therefore,] it is essential [that the therapist] develop a foundation of compassion, empathy, trust, and stability (xxxv).

Spira reminds us that this is similar to the interpersonal relationship style that we should strive to establish with patients with Borderline Personality Disorder. He relates something that Irv Yalom once told him: "75% of the benefit derived from therapy for such persons stems simply from the therapist showing up and being there for the patient. The other 25% of the benefit comes from what the therapist and patient say and do in the sessions" (p. xxxv).

Broadening Yalom's concept, Spira (1996) contends it is not only important what is said in the session, but the clinician must spend time with all of the alters either in direct communication or by "talking through" or relaying information through other alters. Each alter deserves to be "seen" by the clinician. An example of "talking through" would be when the clinician asks the host alter to go inside and seek information from the internal system about a part that is either unable or unwilling to communicate directly. Perhaps the alter is preverbal, does not trust or is restricted by the internal system's rules regarding communicating directly with the outside world. Spira suggests that when working with a client with multiple alters, the clinician should conceptualize the work as similar to family systems therapy, thus, allowing the clinician to be more sensitive to relevant interpersonal issues such as jealousy, fear of abandonment, and being easily angered by others' actions or lack of action. Spira will ask the alters which one requires the most assistance, or if anything major is going on and then explain to the internal system why he is choosing to work with one alter versus another alter. Following his work with one alter, he will then inquire about concerns other alters may have. Frequently, Spira has the client go into a hypnotic "trance," so that he can talk to the group of alters, thus, allowing them to self select who gets to respond. He tries to meet every alter in the personality system and chart their unique features. If an alter is young or shy he may ask to be introduced by an older alter with whom he has a positive relationship (p. xxxvi).

Spira (1996) cautions clinicians that alters may ask them to keep secrets about other alters. He advises the clinician to set a policy regarding the sharing of secrets that states that the clinician will not withhold information from other alters, thus allowing the

clinician to model openness and honesty. However, a clinician must also be flexible at times. An exception might be to keep some information confidential when a situation arises that, in the therapist's judgment, is in the best interest of the entire client or of the therapeutic progress to keep confidential. On the other hand, Spira will encourage the client to share the information with the other alters, or have the client explain to the group of alters that what is being discussed with the clinician must be kept private for the best interest of the group. In fact, according to Spira, the clinician telling the alter that she is willing to receive the information only if it is in the best interest of the group may stop the client from a planned suicide or an attack on other alters.

In addition to Spira's principles, there is a general consensus by many trauma therapists that therapy is divided into phases or stages, terms that are used interchangeably. The number and the names of the stages or phases may vary in different treatment models (Courtois, 1999). I will use the term "stage" generically, but honor the term "phase" when specifically chosen by an author in the literature. The stage oriented models that will be discussed in this paper include: Ross's (2000) Trauma Treatment; van der Hart and colleagues' (2006) Structural Dissociation; Ogden, Minton, and Pain's (2006) Sensorimotor Psychotherapy; Twombly's (2000) adapted version of Eye Movement and Desensitization and Reprocessing; the controversial use of hypnosis (Kluft, 1995; Sapp, 2000); Twombly's guided imagery as a adjunct to hypnosis and Lemke's (2007) use of guided imagery with hypnosis.

Ross's Trauma Treatment Model

In Ross's (2000) Trauma Treatment model, henceforth called simply the trauma model, the three stages are (a) stabilization, safety and education, (b) the active work

phase, or the exploring of memories, and (c) resolution or completion, also known as integration. Ross (2000) contends that the basic environmental needs of "food, shelter, health, education, and safety" (p. 235) must first be addressed, followed by internal stabilization with psychotherapy before a person is ready to do trauma therapy.

The trauma model is further divided into two sub-stages: the PTSD sub-stage and the grief sub-stage (Ross, 2000). In the PTSD sub-stage the symptoms and feelings tend to be those of fear, horror, anxiety, and panic. During this stage there is a lot of acting out behavior, with feelings of anger, instability and turmoil. In the grief sub-stage, the therapist helps the patient explore memories with a focus on mourning the loss of parents who did not provide consistent, loving, affectionate care, and who also should have provided them with basic security, stability, and appropriate discipline. During this stage it has been noted that there is less switching of alter personalities with less acting out behavior. Thus, the patient's internal world is quieter. Ross contends that the grief stage is the most painful stage for the whole Gestalt of childhood is being mourned while, concurrently, the painful memories are still being strongly defended.

While Ross's (2000) trauma model utilizes mostly cognitive-behavioral techniques and strategies to achieve an outcome of changes in cognition, "it is [also] psychodynamically informed and uses many systems principles" (p. 225). Therefore, Ross argues his model could be considered a subset of cognitive-behavioral therapy (CBT). Ross suggests that the trauma treatment model differs from Beck's cognitive treatment model in that the trauma model views cognitive errors as defenses, whereas Beck's model views cognitive errors simply as errors (p. 281). This indicates a few of the complications associated with the choice of treatment approaches.

The two core elements of trauma treatment in Ross's (2000) model are: (a) the problem of attachment to the perpetrator, and (b) the shifting of the locus of control or self-blame with no self-worth. The trauma model assumes that self-worth, safety, and meaning are basic human needs, thus the therapist affirming the patient's value and self-worth through tone of voice, facial expression, and even through body language imparts much of the strength of trauma therapy.

Indeed, because patients with Dissociative Identity Disorder (DID) often blame themselves for the abuse and experience little self-worth, they typically make two cognitive errors about their intrinsic worth. According to Ross (2000), the first cognitive error is that they think they are worthless. The second cognitive error is of a grandiose nature made as a reaction formation defense. Because the patient has been diagnosed with DID, they believe they are special and therefore, have an attitude of entitlement. Ross utilizes simple education to bring about correction. Alternatively, Ross posits that the belief of being special can be reinforced when the therapist is perceived as being more interested in the patient's diagnosis of DID than in the actual person presenting with DID. He further postulates that the appropriate treatment includes correcting the cognitive error of worthlessness, which is the locus of control shift or the shift of blame from the self to the perpetrator. A goal of treatment may be consolidating reversal of the self-blame, which drives suicidal ideations. Ross suggests that trauma survivors ironically may kill themselves seeking safety in death (p. 227).

However, it has also been suggested that trauma patients usually experience their symptoms involuntarily. Ross (2000) contends this has been found to be true for episodes of "age regression, flashbacks, triggering and trauma re-enactments," (p. 228). However,

Ross disputes that *all* symptoms are involuntary. His reasons are first, because people recover from alcoholism, bulimia, PTSD, panic disorder and other AXIS I and II disorders and "if the symptoms were truly involuntary, all forms of psychotherapy would be useless" (p. 228). Secondly, he contends that the symptoms have a social context and communicate a meaning or function and are not randomly distributed in time and space. And thirdly, some symptoms are not involuntary because, "the behavioral interventions can increase or decrease the frequency of symptoms" and there is a "defensive illusion of involuntariness" (p. 229). Ross believes that reinforcing the illusion reinforces the patient role. Furthermore, Ross is not suggesting that the patient can be symptom free with willpower alone, nor that they lack motivation. He does argue however that, "unless the patient has a seizure disorder . . . their behavior is about choices which can be broken down into steps" (p. 229). He also suggests that in order for trauma treatment to work, there is a basic twelve-step principle that is required. That is to say, until the patient makes the fundamental commitment to recovery, no real trauma work can be done.

Ross is in agreement with Krakauer (2001) and others that ethical treatment consists of ongoing consent, which provides evidence of a discussion of goals and progress throughout the duration of treatment. He reminds clinicians of the importance to keep in mind that we are always treating the person as a whole and not the diagnosis, no matter how dissociated the patient might be. He views the diagnosis as a coping strategy to deal with the problem, but not the problem in and of itself. Furthermore, the goal of therapy is not about achieving the status of a diagnosis in remission or about removing the negative. Rather, the goal is a measure of positive growth.

Trauma treatment for DID is also not about removing the patient's defenses. Ross (2000) supports the concept that, "the defenses are part of the person" (p. 233) and they are obviously the challenges. The therapist's task is to work with the defenses. When a child alter, or part, comes out in session and temporarily takes executive control, it is a defense and attempt to rescue the primary host against feelings, perhaps of sadness or anxiety, as well as conflicts experienced in the session. In the literature, the primary "host" is typically described as that part of the personality system that is in executive control most of the time (Braun, 1986; Kluft, 1984; Putnam, 1989). The host is also referred to as the "Almost Normal Part" (ANP) that goes through the daily activities of living, as noted by van der Hart, Nijenhuis, and Steele (2006) in the structural dissociation model to be presented later. Furthermore, Ross contends, the defense, or alter that is "out," that is to say the alter that has temporarily taken executive control, evolves over time as the function, structure, and even the content of the defense evolves and changes. However, it is important to remember that when a child alter is out, it is working in an adult body. The primary focus of trauma treatment is on the function of the symptoms and defenses in the present; it is in the here and now where the healing must occur. Ross illustrates this principle with auditory hallucinations, stating:

> In conventional psychotherapy, the voices are mental warts. The antipsychotic medication removes them or at least is supposed to do so. In trauma therapy, the voices are as much the patient as the patient. The therapist talks to the voices, forms a treatment alliance with them, negotiates with them, and may joke around with them about the foibles and cognitive errors of the executive self, while the executive self is listening. (p. 233)

In the trauma model, Ross (2000) does not identify the voices, "which hold thoughts, feelings, conflicts, and elements of the disavowed personal narrative" (p. 233) as the problem. Rather, "The problem is the executive self's resistance and desire to get rid of the voices" (p. 233).

In fact, it is the conflicts that are disavowed, acted out, or otherwise avoided by the defenses that determine the treatment plan in the trauma model. The auditory hallucinations, negative self-talk, drug addictions, borderline behavior, panic attacks, and compulsive rituals all serve the same defensive purpose. Therefore, a different plan of treatment is not required for each defense. Ross (2000) believes that the diagnosis does not determine the treatment plan. However, since most severely disturbed people have extensive comorbidity, Ross supports a treatment plan that typically requires both medication and cognitive-behavioral therapy, either individually or in a group treatment setting. He proposes a treatment strategy where the idea is to go around the defenses to get to the real work of therapy.

Addictions

A second principle of Ross's (2000) trauma model for Dissociative Identity Disorder (DID) is that the defense is all about avoidance, whether it is avoidance of feelings or conflict. Ross contends, "The avoidance is always about mourning the loss of the parents you never actually had" (p. 238). Addiction distances the patient from their feelings of fear, anger, anxiety, emptiness, boredom, and sadness. Yet, while the content of the client's phobia *is* the content of therapy, the healing takes place at the level of process and structure, not content.

Ross (2000) further defines addiction as a choice that the patient makes. Thus, by defining addiction as a choice, the patient is removed from the helpless victim role and instead is placed in the role of an adult capable of self-regulating their moods in ways that are not harmful. Ross argues that the most serious and frequent addictions practiced by patients with DID are self-mutilation and suicidal ideation. Rumination about suicide provides the patient with a feeling of control. The thought of death becomes their safe place. Suicidal thoughts also provide distraction and reinforcement of the locus of control shift, or the shift of blame. Ross believes that "suicide is the ultimate avoidance strategy" (p. 242).

In the trauma model, treatment always consists of desensitization of a grief phobia. The unresolved grief is the phobic stimulus, which is being avoided. Desensitization involves turning around to face the thing you are avoiding, or facing the "grief." Treatment involves setting up a hierarchy and learning to tolerate the phobic stimulus one-step at a time, which in turn builds healthier, more adaptive coping. In trauma treatment, no matter what problem the patient presents with, the presenting problem is simply the solution to another problem. The symptom always has a social content and a function. According to Nicholas Spanos (1996), "symptoms and behavior are rule-governed and goal-directed" (p. 242). One of the primary symptoms of DID is amnesia, which will be discussed next in relation to the ethics of therapeutic neutrality.

The Ethics of Therapeutic Neutrality

One of the primary symptoms of Dissociative Identity Disorder is amnesia, often concerning childhood memories. In the trauma treatment model, the clinician must maintain neutrality and try not to validate or disconfirm the patient's memories. The

clinician cannot possibly know whether or not the patient's memories are accurate unless there is documented evidence. In fact, because trauma treatment is not focused on memory content, no evidence is necessary. Indeed, trauma treatment patients may hide in their trauma memories to avoid their grief. Ross (2000) contends that validating the patient's memories sets up a power imbalance casting the therapist in the role of adult and the patient in the role of the child. This is counterproductive to the goal of therapy, which is to help the patient achieve independence, autonomy, and self-validation. From a systems perspective, neutrality also keeps the therapist from adopting a position on the victim's rescuer-perpetrator triangle. Thus, the therapist maintains a position of independent consultant, which requires good boundaries (p. 246) while the patient and therapist collaborate to work towards the goal of integration or the attunement of opposites.

Integration of Opposites

The work of trauma therapy for DID is about the integration of opposites. Ross (2000) contends, "Anger . . . is the most effective antidepressant on the market" (p. 251). Some patients hide in their anger to avoid their grief, while other patients hide in their grief to avoid their anger. Both types of patient self-regulate their feelings by dissociating their opposite feelings. The types of defensive strategies that patients use to avoid their feelings include switching back and forth from one mood state to another, addictions, acting out, and cognitive errors. The goal of trauma treatment is not to eliminate opposites; rather, the goal is the attunement of opposites. The goal is to be able to feel opposite ends of the poles and not have to escape the feelings. Ross states, much of the therapeutic work is "practicing sitting with feelings, instead of stuffing, avoiding or

acting them out. . . . The conflict of opposites arises from the problems of attachment to the perpetrator" (p. 251).

Attachment to the Perpetrator

The problem of attachment to the perpetrator is the core of Ross's trauma model. A fundamental developmental task of all humans is attachment to the caretaker to promote survival. Babies are born with attachment mechanisms built into their brain stem and DNA. Ross (2000) posits that a human must attach to the caretaker "in order to grow emotionally, intellectually, spiritually and interpersonally" (p. 262). In addition to attachment mechanisms deep in our brain stem and DNA is a reflex that causes us to recoil from pain. Maltreated children recoil from emotional hurt and abuse by shutting down or dissociating. The trauma model assumes there is a built-in over-ride of the withdrawal reflex by the attachment systems. The maltreated child that must attach to the perpetrator for survival must find a way to believe that the world is safe and the parent good. The child accomplishes this by splitting off the bad feelings and reality or by dissociating. Ross suggests there are two things going on in the child's psyche simultaneously: The child wants to be loved and needs to be connected or attached to the good parent, [or caregiver] while at the same time fearing the abusive parent and wanting to disconnect or flee. The approach and avoidance conflict becomes a conflict deep in the child's psyche or soul. This deep conflict is the same source of pain that drives the symptoms of DID.

Ross (2000) supports the premise that the primary motive for the symptom of amnesia is protection of the attachment system. However, in addition to harming attachment patterns, abuse trauma, especially betrayal trauma (Freyd, 1994) i.e., abuse

perpetrated by a parent or primary caregiver, hurts all aspects of a person's being, including feelings, hypocampal hypofunction, and memories – making them frightening. Abuse also damages cognition and shifts the locus of control, the fundamental grief-avoidance strategy. The evil of the perpetrator is transferred internally to the self, making the perpetrator in the external environment safe to attach to. As previously stated, the fundamental work in trauma treatment is coming to the realization that your parents were not there for you and did not protect you, while the fundamental intervention in the trauma model is verbal psychotherapy. Ross and others believe that verbal psychotherapy reaches deep into the brain and repairs damage to the attachment mechanism.

Therefore, the fundamental process throughout Ross's (2000) trauma treatment model comes to fruition in the third or final stage of consolidation, integration, and resolution. During this stage, the patient is experiencing minimal psychiatric symptoms, is able to function reasonably well in personal relationships, and is beginning to realize their potential in the work place or their career path. Ross suggests that "the trick of therapy is not to let the first third drag on too long" (p. 237).

Critique of the Trauma Treatment Model.

The critique Ross has received about the trauma model from cognitive therapists is that he is not really doing cognitive therapy, while psychoanalytic therapists accuse him of denying the existence of the unconsciousness and doing cognitive therapy. On the other hand, Ross (2000) notes that false memory syndrome advocates accuse him of doing unscientific Freudian or psychoanalytic therapy. Ross disputes these critics, denying that trauma therapy is "eclectic." He explains the trauma model as being coherent with a restricted range of applications, and subject to empirical treatment

outcome studies. He points out that it is distinct from Beckian cognitive therapy for depression, and it is not family therapy or psychoanalysis. According to Ross, in addition to drawing its principles from all three above mentioned schools of thought and from social psychology, the trauma model incorporates developmental psychology and the biology of Bowlby's attachment theory. Moreover, Ross contends "Trauma therapy is useless for a lithium-responsive clear-cut bipolar patient with no comorbidity or for a deteriorated schizophrenic with fixed auditory hallucinations" (p. 252).

In summary, Ross (2000) supports cognitive-behavioral therapy (CBT) even though much of it can be translated into psychoanalytic vocabulary. He believes CBT is superior because it has an "empirical mindset with cognitive therapy generating more evidence of its efficacy in a year than psychoanalysis has in a century" (p. 253). And finally, Ross contends that psychotherapists have a moral, ethical, and scientific obligation to devise and utilize testable models of treatment. Other testable models will be presented below.

A Contemporary Theory of Structural Dissociation and a Model for Treatment

Since Pierre Janet (1859-1947) first introduced a theory of dissociation to describe the structure of a severely traumatized or dissociative patient's personality system as one that lacked cohesion and flexibility, many confusing and contradictory definitions have been presented in the literature. Indeed, with the original definition losing its specificity over time, many treatment approaches with the goal of integration have proven to be unsuccessful resulting in the dissociative patient being labeled as resistant or untreatable (van der Hart, Steele, & Nijenhuis, 2006). Whereas dissociation was once believed to be a division of consciousness, Janet wrote in 1907 that it was a

division among various "systems of ideas and functions that constitute personality" (as cited in van der Hart et al., p. 3). Janet also defined ideas as being equivalent to an internal language with internal reactions and without external direction (Heim & Buhler, 2006). Moreover, Janet saw ideas as a whole system of images and tendencies continuously transforming themselves with their function being to stimulate thinking, leading to more complex behaviors found in a hierarchy of action tendencies. Indeed, Heim and Buhler contend that individuals exposed to the emotions of "fear, rage, or sorrow, or to feelings of incompleteness and disturbed cognitive processes" (p. 112) could develop *"idees fixes,"* meaning fixed or rigid ideas. When one combines the concept of *idees fixes* with the idea of a whole system of images it seems to describe the internal system of alters described by patients with dissociative identity disorder. Additionally, van der Hart et al. contend that rigid ideas lead to a loss of psychological energy with a weakening of action tendencies. Rigid ideas also lead to a diminution of psychological synthesis, which in turn, inhibits the patient from personal awareness and integration of the trauma into their autobiographical narrative.

Indeed, van der Hart, et al. (2006) are in partial agreement with Resch's (2004) premise that there is a deficiency in cohesiveness and flexibility of the personality structure of a person with structural dissociation, or complex trauma. However, they have expanded the theory by Janet's original theory of structural dissociation with his psychology of action theory and thus, have created a new, contemporary theory of structural dissociation.

The new contemporary theory suggests that in addition to lacking cohesion and flexibility, the dissociative patient's personality system is organized in such a manner that

their mental and behavioral actions are maladaptive, and therefore, they are not integrated. Van der Hart el al. (2006) describe integration as that which connects a person's thoughts, memories, feelings or emotions, actions and sense of identity, and that this process involves two major mental actions: synthesis and realization.

Van der Hart et al. (2006) describe synthesis as a series of specific mental and behavioral actions that bind or differentiate our perceptions, affects, cognitions, and body movements in the present moment and across time to promote survival. In synthesis we link and differentiate components of our experiences. For example, we differentiate the relevant from the irrelevant stimuli to function adaptively. We bind, or link, certain components together such as the color and shape of an object, which give us a visual perception. Some perceptions may be unconsciousness and only require low levels of mental energy and efficiency. In contrast, when we need to direct our attention to a more complex situation, we need higher order mental actions that are conscious, voluntary, and complex. Indeed, higher order mental actions require higher levels of mental energy and efficiency or, according to van der Hart et al., require a "high synthetic action that occurs on a continuum of complexity" (p. 134). It is the actions of synthesis that are the foundation for realization, which involves meaning making.

The dissociative patient, unable to realize, or to know their past, struggles with their daily life activities. Without "realization," a higher-level mental function, the patient does not know that the past is not the present and thus their actions reflect confusion. Lacking realization, or the ability to create an autobiographical narrative of their life history, these patients are unable to "create a cohesive sense of time, reality, self, and

experience" (van der Hart et al., 2006, p. 151). Van der Hart et al. further define realization as having two components, "personification," and "presentification" (p. 153).

Janet, as interpreted by van der Hart et al. (2006), believed that personification involves the capacity to take personal ownership of an experience (p. 153). The patient who can personify is consciously aware that the event is happening to them, but it is how they perceive the event that will affect their actions or behavior. According to van der Hart et al., "Personification thus connects our sense of self with past, present, and future events, and with our own mental and behavioral actions, giving us a sense of agency" (p. 153). Without this connection, the dissociative patient lives in a state of chaos struggling to cope with their daily life activities and to make meaning of their lives. The dissociative patient's challenge is to be able to personify his or her experience both in the moment and across time, with each part of the personality system being able to claim ownership of the experience, feeling that the experience is happening in one body and with one history: It is happening to me. Personification is indeed a difficult task and takes a great deal more mental energy and efficiency to personify overwhelming traumatic events. Van der Hart et al. suggest that a goal for patients with structural dissociation, or a diagnosis of DID or DDNOS, is to be able to transfer skills or action tendencies across different parts or across "different senses of self" (p. 155), and to personify their experiences both in the present moment and across time.

Presentification, the second component of realization, is described as the ability to simultaneously be present in the moment and act in the moment in a highly reflective manner. Dan Stern (1980) describes being present or "presentness" as experiencing "the moment of subjective experience as it is occurring" (p. xiii). According to van der Hart et

al. (2006), "presentification is our construction of the *context* and *meaning* of the present moment within our personal history" (p. 157). Furthermore, presentification is a complex action and requires our highest levels of mental energy and efficiency. Indeed, the action of presentification is compromised when patients with structural dissociation are distracted, or when they totally shut down, or "collapse," under extreme stress. Sustained presentification in the moment, across time, and under stress is the ultimate goal.

Treatment for DID and DDNOS, according to the new structural dissociation model, is a long-term, phase-oriented [or stage oriented] approach that identifies the patient's maladaptive mental and behavioral actions and supports them while they learn more effective mental and behavioral actions. It is the belief of van der Hart et al. (2006) that it is because trauma survivors do not have adaptive actions that they are unable to integrate their traumatic history. Indeed, in order for the patient to have adaptive actions they must first achieve an adequate "mental level," meaning they must have a sufficient balance between their "mental energy" and "efficiency." Van der Hart et al. propose four simple principles in the structural dissociation's mental economy model: (a) *Increase* mental and physical energy, (b) *Decrease or eliminate* unnecessary mental energy, (c) *Reduce and eliminate debts,* meaning any unfinished business from the patient's history, which includes relationship issues, emotional issues, or any stressors that are contributing to draining their mental energy and inhibiting their mental efficiency, and (d) *manage available energy* by increasing mental efficiency or adaptive actions. The treatment principles can be understood as promoting a "mental economy" in which "mental energy must be produced, conserved and spent wisely" (p. 239).

Furthermore, van der Hart et al. (2006), in keeping with Janet's theory that dissociation is a division of the personality's "systems of ideas and functions" (p. xxx), argue that divisions of the personality primarily take place between the two major categories of approach and avoidance. People approach attractive stimuli and avoid aversive stimuli. These psychobiological action systems are not arbitrary, but necessary and goal directed for the purpose of survival. The structural dissociation model suggests three stages of treatment with each stage focusing on a specific set of economic principles and addressing specific phobias.

Phase One: Symptom Reduction and Stabilization

During the first stage of structural dissociation treatment, the focus is on addressing the phobia of trauma-derived mental action, which is considered the *sin quo non* necessary to prepare the patient to address dissociative parts and trauma memories in later phases of treatment. Van der Hart et al. (2006) describe mental actions as "what we feel, think, wish, need, and sense" (p. 281). Survivors of complex trauma avoid, or inhibit, mental actions because they misperceive them. For example, thoughts assign meaning to our lives; wishes help us to formulate goals and direct us where to spend our energy; body sensations help us to recognize our emotions, tell us if we are sick, and determine how we move and act. By avoiding or inhibiting mental actions, patients deprive themselves of a rich source of important information that can guide them in daily life. Hence, they have a trauma-derived phobia of mental actions. Two major interventions employed to help the patient overcome their phobia to traumatic-derived mental action are the therapeutic relationship that serves as a regulating factor (D. Brown, Scheflin, & Hammond, 1998; van der Hart et al., 2006), and "the patient's development

of regulating skills either taught by the therapist or in a skills training group" (van der Hart et al., p. 283). Treatment during phase one will also be devoted to overcoming the phobias of attachment and attachment loss with the therapist, with an overall goal of increasing mental energy.

During this phase the patient will practice regular self-care by getting the proper amount of rest, recreation, exercise, eating a healthy diet, and practicing disease prevention, stress reduction, and relaxation training. Psychoeducation, which can be used in any stage of treatment, is an important intervention in the beginning stage that is utilized to raise the patient's mental efficiency. Van der Hart et al. (2006) find it helpful to explain to the patient the nature of traumatization and structural dissociation, pacing the amount of information given according to what the patient can integrate. It is a very difficult concept for patients to grasp that structural dissociation means that they have different parts to their personality. Psychoeducation also includes helping the patient understand the three different forms of structural dissociation, how the division of parts was essential to the patient's survival in the past, and the purpose or function of the parts in the present.

The most basic form of structural dissociation is *primary* dissociation. Van der Hart el al. (2006) suggest that primary dissociation consists of a personality with two parts. One part is the Apparently Normal Part of the Personality (ANP) that is dedicated to daily life activities and the *avoidance* of traumatic memories. The second part is an Emotional Part of the Personality (EP) that defends against threat and holds the traumatic memory. In Ross's (2009) analysis of the structural dissociation model he notes that in

the basic configuration the ANP is the "host personality" or the "depleted executive self" and the EP is a "child alter personality" or an "ego state" (p. xxx).

In *secondary* dissociation, van der Hart et al. (2006) contend there is *one* ANP focused on daily life activities, and *more than one* EP containing various aspects of the traumatic memory or different traumatic memories and focused on defending against threat. And finally, in *tertiary* dissociation, there is *more than one* ANP dedicated to daily life activities and *more than one* EP, defending against threat. It is the clinician's responsibility to help the patient understand their diagnosis by sharing the data from the assessment and by making the patient aware of problems that are related to the diagnosis. In the beginning stage of treatment, the patient most likely will not be aware of all the dissociated parts and it may take time, perhaps years, for the therapist to identify the total number of parts.

It is also important that the clinician explain the phase-oriented treatment plan to the patient, noting that each of the three treatment stages, which do not always progress in a linear process but may shift back and forth, can be described in terms of overcoming specific phobias. Additionally, the clinician must educate the patient that the therapeutic relationship, with ethical boundaries, is an important part of the treatment, as well as educating them about the importance of healthy boundaries in non-therapeutic relationships. Furthermore, patients need to be taught how to balance their daily life activities, how to promote "internal empathy and self-care among all parts" and how to "relax the defensive action tendencies of various parts toward each other" (van der Hart et al., 2006, p. 248).

Promoting self-care and internal empathy involves having the clinician share with the Apparently Normal Part (ANP) essential information learned from various other parts of the personality system that the "host," or ANP, is unaware of or does not understand. Raising the mental efficiency can stimulate the patient to engage in more advanced action tendencies; however, providing the patient with verbal information alone may not be enough. Dissociative patients often distort information due to inaccurate perceptions and some parts that are able to hear the information may not want to share the information, thus blocking it from other parts. Van der Hart et al. (2006) suggest writing down or audio taping essential information for patients to take home if they are agreeable.

The Structural Dissociation model is similar to Ross's (2000) Trauma Treatment model in identifying the phobia of attachment as a core problem for survivors of complex trauma. Survivors face a paradox in that they often avoid attachments because they are perceived as a *threat,* yet, at the same time, they also feel threatened by the loss of an attachment figure. These patients expect that they will be betrayed based on their past experiences. Van der Hart et al. (2006) contend this is because "their perception-motor action cycles remain strongly influenced by the defense system which causes them to be unduly focused on relationship threat cues" (p. 241). It is through the gradual development of a secure attachment to the clinician that serves as a regulating factor (D. Brown et al., 1998; van der Hart et al., 2006), or through the "development of regulating skills" (van der Hart et al., p. 283) that the patient is able to achieve the much-needed psychophysiological regulation that will improve their mental efficiency. Van der Hart et al. state, "The secure therapeutic relationship and therapy frame are the *sine qua non*

[italics added] of effective psychotherapy with chronically traumatized individuals" (p. 241).

Establishing a secure attachment with survivors requires *empathic attunement.* Van der Hart et al., 2006) acknowledge J. Wilson and Thomas (2004) in defining empathic attunement as "The therapist's consistent empathy with the patient's experiences of him or herself and others, the therapist's awareness of and adaptive responses toward the patient's dissociative parts, and the therapist's ability to offer the possibility of secure attachment" (p. 241). It has been suggested that while being empathic, which serves to decrease the patient's need for defensive actions, simultaneously the therapist must "support activation of other action systems such as attachment, sociability, and exploration" (p. 241). Additionally, a secure attachment requires an appropriate therapeutic frame.

It is within the therapeutic frame where the roles of the clinician and the patient are negotiated and clearly delineated early in treatment (Chu, 1998a; Courtois, 1999; Dalenberg, 2000; Pearlman & Saakvitne, 1995; van der Hart et al., 2006). The therapeutic frame includes ethical boundaries, limitations, and rules of therapy that are flexible, yet, within limits and that thus, support the establishment of a secure attachment. The boundaries may include the frequency of sessions, the number of extra sessions allowed, the number of phone contacts allowed between sessions, even the time of day calls may be placed to the therapist. According to van der Hart et al. (2006), boundaries help provide an "optimal balance between relational closeness and distance between therapist and patient" (p, 242). Van der Hart et al. further state, "Boundaries protect patient and therapist from becoming too overwhelmed by the demands of such difficult therapy,

which can result in lowered mental energy and insufficient mental efficiency" (p. 242) for both patient and clinician. In fact, the clinician can become resentful if they accept daily crisis phone calls or attachment cries from various parts of patients with structural dissociation. When these practices are allowed, the patient does not improve, but rather continues to escalate, contributing to the possibility of the clinician becoming overwhelmed. Lastly, the therapeutic frame must be monitored and maintained over the course of treatment. Keeping the rules of therapeutic frame consistent and predictable whenever possible will help to provide a feeling of safety to the patient.

Indeed, an important factor in establishing the therapeutic frame is safety. Before patients with structural dissociation are able to reach the level of mental energy necessary for reflective thinking, they must feel safe within the therapeutic relationship. Patients will not feel safe if the clinician is experienced as inconsistent and unpredictable. Moreover, a healthy therapeutic relationship that is emphatic and supportive will help to provide the much-needed feeling of safety and security, but even this is still not enough. Unfortunately, many patients drain their mental energy bank account by feeling unsafe, living chaotic life styles, and having obsessive thoughts. Some patients obsess over relationships that require a high level of maintenance. They have to work double-duty to make the other person happy. Other patients obsess about achieving perfection and getting everything done to avoid punishment. Lots of frenetic activity becomes their coping style or survival mechanism, In fact, trauma survivors often choose to be in relationships with people who are insecurely attached and who are masters at inducing guilt leading to excessive caretaking which, in turn, triggers the patient's defensive action system causing the patient to fear abandonment and rejection. At times the trauma-

survivor patient may evoke reactions in people that will cause them to reject them, leading to an endless cycle of relational conflicts and keeping the patient in a low mental energy level. Thus, in the first stage of treatment the role of the clinician is to help the patient learn to decrease stress, use their "energy management action system more adaptively" (van der Hart et al., 2006, p. 244), and to increase their mental and physical energy level. One of the ways a patient raises their mental level is with a secure attachment, which allows for more flexible functioning (Schore, 1994).

A secure attachment also supports development of other action systems needed in daily life (van der Hart et al., 2006, p. 264). Unfortunately, chronically traumatized patients are also challenged by a secure attachment because they have internalized mental representations of malevolent abusive attachment figures that represent one or more of the dissociative parts of the personality system (Blizzard, 2001, 2003; Howell, 2005; Liotti, 1995, van der Hart et al., 2006). As survivors, these patients have never developed a capacity for self-soothing and misread relational cues from the clinician as dangerous. They believe that the clinician will try to control them and hurt them. They are also unable to evaluate the therapy situation, thus evoking in them defenses while paradoxically clinging to the clinician. Furthermore, these patients are experiencing a phobia of attachment on the one hand, and a phobia of attachment loss on the other hand; it is this conflict that is "the essence of disorganized/disoriented attachment" (van der Hart et al., 2006, p. 265).

Yet, in spite of this conflict, the therapeutic relationship is the matrix of therapy. A secure attachment to the clinician is essential for a successful treatment (Alexander & Anderson, 1994; Kinsler 1992; Laub & Auerhahn, 1989; Olio, & Cornell, 1993; van der

Hart & Nijenhuis, 2005; van der Hart, Nijenhuis, & Steele, 2006). Therefore, a major treatment goal during stage one of treatment, as well as across all stages of treatment, is for the patient, as well, as the clinician, to balance closeness and distance to promote higher mental levels. The clinician must remain alert to the fact that the patient's attachment issues can evoke countertransference issues of enmeshment or distancing (J. Wilson & Lindy, 1994; J. Wilson & Thomas, 2004; van der Hart, Nijenhuis & Steele, 2006). Van der Hart et al. (2006) assert attachment issues must be attended to consistently in every interaction with the dissociative patient.

In addition to reenacting trauma attachment patterns with the clinician and with significant others, the patients are also reenacting the same patterns internally with dissociative parts. Thus, it is also the clinician's responsibility to help the patient resolve maladaptive internal relationships. Clinicians are cautioned by van der Hart et al. (2006) that when their own mental level is low it may contribute to them feeling overwhelmed with powerful affects that include guilt, love, pity, rage, or shame. The clinician may then act on these feelings, engaging in defensive actions by distancing himself or herself from the patient instead of providing a consistent attachment figure. Van der Hart et al. contend, "It is crucial that the therapist seeks a degree of optimal closeness and distance so that the patient's approach-avoidance conflict [phobia] is contained within his or her tolerance level (i.e. the current mental level)" (p. 269).

The clinician must always keep in mind that the structural dissociation model is a mental economy model and that maintaining phobias consumes much of the patient's expended energy, which is a major obstacle to improving mental efficiency. Additionally, according to van der Hart et al. (2006) "Trauma-related phobias are the most pervasive

form of [maladaptive] substitute actions" (p. 256). Treatment involves helping the patient in several ways: (a) helping them to realize their phobias, for example learning that the churning in the pit of her stomach does not always signal danger, while preventing maladaptive actions such as panic, cutting, or substance abuse, (b) assessing for trauma-derived phobias and ranking their degree of severity, and (c) helping the patient verbalize his or her fear, which is a higher order action tendency. Each time that the patient experiences the feeling of fear while in the supportive therapeutic relationship and realizes that it is not dangerous in the present moment, there is a transformation taking place that raises his or her mental efficiency.

Moreover, it is crucial that the clinician also helps the patient overcome the phobias of his or her inner world, including the phobia of shame, fear, love or needing contact with others, wishes or fantasies, phobias of his or her own body, and the phobias of dissociated parts. The clinician, using a family systems approach, must work with the internal relationships, including both the parts that fear abandonment and rejection, and the parts that eschew attachment. The clinician's role is to support the patient as they develop an adaptive dependency with a goal of a "felt sense of security" (van der Hart et al., 2006, p. 275) and the ability to depend on more functional parts of themselves. Through gradual exposure to conditioned stimuli the patient will be able to engage in the mental actions of synthesis and realization.

Phase Two: Treatment of Traumatic Memories

During stage two of treatment when the dissociative parts are no longer avoiding trauma-derived mental actions, treatment focuses on helping the patient "synthesize" and "realize" his or her core phobia of traumatic memories (van der Hart et al., 2006, p. 319).

The goals of treatment in stage two include continuing to increase the patient's mental level and achieving a balance between mental energy and mental efficiency. Then, gradually at a level the patient can tolerate, also referred to as a "window of tolerance," expose the patient to adaptive feelings, which patients with DID and DDNOS tend to avoid. Van der Hart et al. contend that catharsis is contraindicated because experiencing vehement emotions can cause severe imbalance between mental energy and efficiency or physiological dysregulation.

Interventions may include physiological regulations, for example, grounding and breathing exercises, and cognitive techniques that support reflective awareness and thinking about inner experiences, also known as developing a theory of mind or "mindsight" (Siegel, 1999). Indeed, patients who have been chronically traumatized typically have "inaccurate perceptions of the present and catastrophic predictions of the future" (van der Hart et al., 2006, p. 289) causing the patient to experience vehement emotions, which are not intense feelings, but are lower-order substitute actions that maintain the phobia of mental actions. A significant intervention is "to help the patient or the dissociative emotional part (EP) stop vehement emotivity" (p. 289) and instill adaptive actions, thus increasing mental efficiency. When the patient experiences feelings of shame it produces actions of "withdrawal, freezing, submissive behavior and fight responses" (p. 290). When they experience feelings of fear, which is a central factor in maintaining dissociation, often inhibiting mental actions or feelings of disgust, guilt, panic, or rage they also feel helpless and hopeless. To transform the patient's vehement emotions into adaptive actions and increase mental efficiency, the therapist might ask the patient, "What are you feeling in the present moment?" This question may be followed

with interventions which might include: grounding and breathing techniques, encouraging the use of language, encouraging presentification or staying in the present, and staying in a relational context. Having the patient try to make meaning of the feeling is not yet encouraged. Additionally, van der Hart et al. suggest referring the patient for a psychotropic medication evaluation to help regulate his or her physiology.

Another source of information about mental actions is gleaned through physical sensations and movements (Ogden, Minton, & Pain, 2006). "Chronically traumatized patients all have some degree of phobia to their bodies due to shame and disgust" (van der Hart et al., 2006, p. 295) especially if they have been sexually abused (Andrews, 2002; Armsworth, Stronk, & Carlson, 1999; Goodwin & Attias, 1999). Body shame can involve the sensory modalities of taste, smell, sounds, and sights (Gilbert, 2002). The phobia is based on the belief that their body is disgusting and can relate to the body's appearance, a bodily function, or a specific body part. Body phobias may also include maladaptive behavioral actions that are inhibited or activated by the phobia. In fact, an inhibited patient will avoid whatever feels shameful about the body. For example, an inhibited patient may avoid looking in a mirror or changing clothes in front of other people in a locker room. In contrast, if the patient's phobia is triggered, maladaptive behaviors can range form excessive bathing to self-harm, even to the extreme act of cutting off a body part.

A helpful intervention is for the therapist to direct the patient's attention to their physical experience in the moment. By observing the patient's sensorimotor experiences, the trained therapist is able to guide the patient into more adaptive regulation and tolerance of mental activity. For example, the therapist may notice increased breathing

and ask if the patient is aware of it to encourage "presentification" (van der Hart et al., 2006, p. 288) or being aware of their experience in the present moment. It is only when the patient has sufficiently learned to tolerate the affect or experience that the therapist should work with the patient on making meaning of the affect. Therapists should proceed with caution and note that the patient with DID or DDNOS can be easily triggered and thus, become enraged at the therapist for a comment that may seem benign. In turn, the therapist may be caught off-guard and make a defensive comment rather than a supportive and empathic comment. When this happens, in the very next session, when hopefully both the therapist and patient have a higher mental level, the therapist should attempt to repair the relationship by asking the patient what would have been more helpful. This intervention provides a new prediction about the outcome of getting angry at the therapist and it helps to teach the patient another way to communicate their feelings of anger without raging.

In summary, phobias about mental actions signal unresolved trauma. The therapist must explore with the patient their experience of mental activity and utilize the techniques previously described to resolve these types of phobias. Yet, there is still a more difficult phobia left to treat; the phobia of dissociative parts that is often neglected in the therapy sessions.

Treating the phobias of dissociative parts requires additional therapeutic interventions that not all therapists practice with the goal of increasing the patient's capacity for adaptive action and integration. Successful treatment requires that the dissociative parts develop internal empathy for each other, strategize a working alliance, and realize that they are all parts of a single "I" or a personification (van der Hart et al.,

2006, p. 301). A unique element of the structural dissociation treatment model is the strong emphasis that in order for the dissociative patient to overcome the phobias of parts, both the patient and the therapist must have a high level of mental action. The therapists must be able to help the patient engage in actions that "promise synthesis and realization within the personality as a whole" (p. 301).

Interventions include the therapist modeling respect and fairness to all parts because all interventions have systemic consequences. In fact, Kluft, (1993a, 1999) advocates for the therapist to avoid working predominately with any one part and ignoring other parts. Modeling by the therapist is a powerful intervention because it allows the dissociative parts to become aware of each other, and to understand how they operate as a whole personality system. Prior to exposing parts to each other, it is important that the therapist explore with the patient why the parts are phobic of each other. What do they fear? The patient is "gently encouraged to be more reflective and engage in experimental actions with a goal of parts completing unfinished actions that they may be fixated in" (van der Hart et al., 2006, p. 303). The therapist does this by helping the Apparently Normal Part(s) (ANP) that functions in daily life to work with the Emotional Part(s) (EPs) that is (are) stuck in a trauma-related action to build safety and increase mental energy. If the ANP(s) does not have enough mental efficiency to help the EP(s), therapy is then focused on first raising the mental level of the ANP(s). The therapist must remember to gear interventions to the appropriate mental level. A patient with a lower level of action tendency will need to be taught a non-verbal technique to communicate. An example would be to have a non-verbal part hold up one finger to give

a "no" response to a question and hold up two fingers to give a "yes" response to a question (p. 303).

When treating a patient for a phobia of dissociative parts, the therapist must always remember to think systemically knowing that all interventions are "geared to reach as many parts as possible" (van der Hart et al., 2006, p. 309). This requires empathic curiosity by the therapist, who should explore why parts avoid other parts and encourage the parts to work more adaptively while continuously reminding the patient that all parts belong to a single person. An example of a systemic intervention would be to encourage an EP to "talk through" an ANP (p. 309), meaning the EP would communicate internally to an ANP who would then communicate the information to the therapist.

A second systemic intervention is exposing parts to each other with specific goals for each part. For example, one part's goal might be to share knowledge with another part, or to share skills with another part.

A third systemic intervention is working individually with a part with a goal of raising their mental efficiency before introducing them to other parts. This intervention is utilized with parts that have very low mental levels and who are the most phobic. Van der Hart et al. (2006) caution therapists not "to underestimate the degree of avoidance of an ANP toward an EP and visa versa" (p. 310). In my own practice, I have found that it is not unusual for dissociated parts to have internal rules of engagement regarding which part may communicate with another part, sometimes requiring several parts to become involved passing the information along like an assembly line. Additionally, some parts

may not have acquired language; some may be mute, while others may be deaf or even blind.

Indeed, while the therapist must work with many different types of dissociative parts, the most common and problematic parts for the therapist to work with are the persecutor, fight, and child parts. Persecutor parts are EPs that have identified with the perpetrator and are defending horrific traumatic memories. However, the behavior of the persecutor part, according to Ross (1997) is not the problem, but the solution to the problem. The therapist's challenge is to understand what the real problem is and to help the system find more adaptive solutions. Persecutor parts (there may be more than one persecutor part) usually work to sabotage therapeutic progress. Therefore, the therapist must work to raise the patient's mental efficiency, create a safe relationship with the parts, correct cognitive errors, understand the part's shame, and reduce any feelings of hatred and fear that parts have for each other. Successful treatment, according to the structural dissociation model, requires that the therapist be fully engaged with the persecutor EPs.

The same treatment principles utilized in working with persecutor parts applies to working with protector (fight) Emotional Parts, with a slight difference. Fight EPs are stuck in the action subsystem and have more mental energy than mental efficiency. They can become easily angered and see the therapist through the lens of danger and threat. It is important that the therapist be "respectful, predictable, and as consistent as possible" (van der Hart et al., 2006, p. 313). The therapist's role is to help the *fight* EP turn rage into adaptive anger and learn to express it appropriately.

When working with *child* parts that hold traumatic memories and often hold intense pain, feelings of loneliness, terror, and shame, the therapist must carefully pace the work and gear interventions to their mental level. Too intense therapeutic work with child parts can reactivate the trauma memories and substitute actions: for example, cutting or other self-harming behaviors. Furthermore, experiencing the child part's intense feelings can cause the therapist to either withdraw from the patient or to become enmeshed with the patient. Child parts also tend to be needy and are fixed in an attachment-related action system where the ANP(s) wants the therapist to be a caretaker to the EPs and "fix" the problem. The therapist job is not to "fix" the problem, but rather to help the child parts to be able to regulate themselves. It is the patient's responsibility to accept all parts, thus allowing himself or herself to integrate memories into an autobiographical narrative, which prepares the way for the treatment work of phase three: integration.

Phase Three: Fusion of Personalities

When patients have accepted and learned to cope with all parts of their personality system, the next step and goal is fusion, "the act or instance of bringing together two or more [parts of the personality] personalities or fragments in order to blend their essence into a single-entity" (van der Hart et al., 2006, p. 315; see also Kluft, 1993a). Van der Hart et al. note that some clients resist fusion because "they may have come to value various 'separate' parts as powerful internal transitional objects, and strongly grieve their loss" (p. 338). Yet other patients will allow fusion of some parts, but resist full integration.

Interventions for those patients who are willing to work on integration include the therapist helping the patient to "become less divided and emancipated over time" (van der Hart et al., 2006, p. 338). Some patients will leave therapy during phase three because it becomes unbearable for the patient to realize that they were rejected by their parents or never loved by them. This type of realization demands the highest mental level. If the patient decides to go through the process of fusion or integration and wishes to stop when the process becomes too difficult, the ethical therapist will respectfully honor the patient's decision to stop and return to fusion at a later date, or not at all.

For those patients who choose to work on integration, the therapist might guide the fusion of dissociative parts with formal, planned fusion rituals, with or without hypnosis. The use of metaphors is often helpful in fusion rituals. For example, the therapist would tell the patient "hold hands" with other parts and visualize them "stepping into each other," "being in a circle together" and "walking toward a healing light" (van der Hart et al., 2006, p. 229). Encouraging the temporary blending of parts is yet another intervention (Kluft, 1993b). Fine and Comstock (1989) suggest experimenting with some parts simulating fusion for a brief time, and later practice the simulated fusion in their daily routine. It is important for the therapist to always be respectful and invite the patient to participate in fusion rituals and to ask them if they can think of any reason why the parts should not be together.

In this final phase of treatment, "Integration of the Personality and Overcoming the Phobias of Normal Life," the ultimate goal is full integration where the Apparently Normal Parts (ANPs) and the Emotional Parts (EPs) will no longer be divided, but rather will be able to utilize the highest action tendencies possible, especially the action systems

of exploration and experimentation to contribute to the patient's overall quality of life. This may be the most painful phase of treatment because the process requires that the patient grieve and relinquish core beliefs that were needed for survival. Moreover, the patient will need a high degree of mental energy to learn to adapt to life "with new mental and behavioral actions" (van der Hart et al., 2006, p. 337).

During phase three, it is also possible that additional memories and additional parts of the personality will emerge. This is to be expected when treating complex trauma because typically, what appears to be the "final fusion" between dissociative parts is not final at all. Kluft (1993b), asserts that only after 27 months of no further manifestations of dissociation in DID patients may one safely assume that integration is indeed secure, indicating a need for thorough and prolonged follow-up. In the event that new parts to the personality do emerge, with the patient's permission, the therapist must return to phase-one or phase-two in treatment until all parts have been integrated.

In summary, treatment utilizing the structural dissociation model consists of supporting the patient while they become able to sustain personification and presentification. With the support of the therapist, the patient develops the highest action tendencies and is able to engage in highly complex mental and motor actions. The patient should be able to explore their world, want to do it, and not be afraid to try new things. They are now able to derive meaning in their lives. The patient's final challenge now is to live a normal and less chaotic life.

There is a Zen saying, "Before enlightenment, chop wood, carry water; after enlightenment, chop wood, carry water." This means that our patients need to be able to have personification and presentification even in the mundane actions of life.

Sensorimotor Psychotherapy

Sensorimotor Psychotherapy, a new school of therapy founded by Pat Ogden (2004), integrates attachment theory, neuroscience, and traditional psychotherapeutic practice. This new therapy is a three-phase, body-oriented trauma treatment model with guidelines and interventions for each phase and an over-arching goal of integration. During phase one, *Developing Somatic Resources for Stabilization* the focus is on assessment, symptom reduction, and stabilization, which involves reinstating lost resources, learning new resources, and strengthening existing resources. In phase two, *Processing Traumatic Memory and Restoring Acts of Triumph*, the primary goal is more specifically "on the phobic avoidance" (van de Kolk & van der Hart, 1991 of memories rather than on the retrieval of traumatic memories which could retraumatize the patient and lead to further destabilization. In phase three, *Integration and Success in Normal Life,* the final phase of treatment, the focus is on completing personality integration by empowering patients to challenge themselves to try new activities, and by developing an ability to experience intimate relationships along with other normal pleasures in their daily lives without intrusive memories.

Although the goals of sensorimotor psychotherapy therapy will be presented in a linear fashion, therapy is not a linear process. During phase two, when working on memories, and even during the final phase, new memories, or memory fragments, may arise and begin to destabilize the patient. Ogden et al. (2006) suggest that access to these memories is, "perhaps due to the client's increased integrative capacity that enables tolerance for previously dissociated memories" (p. 268). When the patient has become

destabilized, the therapist must return to phase one work to resource the patient. According to Ogden et al.,

> Helping patients develop a more integrated self entails providing support, facilitating resourcing, guiding trauma processing, challenging maladaptive action tendencies and practicing alternatives in real life always proceeding at a pace that allows the patients to stay resourced and maintaining or expanding their window of tolerance. (p. 269)

Phase One: Stabilization

Phase one treatment interventions are designed to help the patient increase integrative capacity and function more adaptively in daily life (Ogden et al., 2006, p. 206). Integrative capacity is raised when the patient becomes mindful of somatic sensations and movements and learns how to utilize both internal and external resources to stabilize and to self-regulate her excessive arousal or the physiological state of the central nervous system (p. 244). The therapist begins with the traditional history taking, but includes nontraditional body-oriented assessments, external, and somatic resources. The patient's internal resources may include implicit or procedural memory skills, which "refers to memories of skills and habits, emotional responses, reflexive actions, and classically conditioned responses" (van der Kolk, McFarlane, & Weisaeth, 1996, p. 281), such as the ability to drive a car, utilizing professional skills, and even survival skills. While internal resources may also include interpersonal relationship skills, external resources may include social support systems. Other external resources include housing, employment, financial status (ability to pay for therapy), transportation (to attend therapy), access to medication, access to other needed services, and so forth. In fact, both

internal and external resources need to work in tandem to enable the patient to attend therapy sessions.

Finally, the patient's somatic resources are evaluated through "body-reading" and "body-tracking." While traditional therapists tend to track the patient's presenting affect, thoughts, and narrative, in sensorimotor psychotherapy body-tracking is considered a foundational skill. As defined by Ogden et al., (2006):

> Body-reading refers to the observation of persistent action tendencies . . . and helps therapists become aware of the client's chronic patterns of physical structure, movement, and posture that remain consistent over time and are correlated with longstanding beliefs and emotional tendencies. . . . *Tracking* refers to the therapist's ability to closely and unobtrusively observe the unfolding of nonverbal components of the client's immediate experience: movements and other physical signs of automatic arousal or changes in body sensation. (p. 189)

In other words, body-reading informs the therapist if the patient's body is communicating an enduring pattern of being defensive of their environment based on previous traumata, versus feeling safe in their body and being open to socially engage with their environment. Body-tracking by the therapist helps the patient become aware of their somatic presentation in the present moment-by-moment experiences. In addition to tracking negative body experiences, Ogden et al. (2006) suggest tracking positive experiences in the patient's body. For example, if a slight smile is observed, the therapist would ask the patient about the smile, bringing it to their awareness and thus helping the patient connect the positive or pleasurable sensation to a positive memory. Experiencing pleasurable sensations will be elaborated upon when discussing phase three.

When assessing patients for somatic resources it is helpful to point out to them how working with the body in phase one will help to stabilize them when later addressing memory work in the second phase of treatment. During the assessment phase the therapist will also teach the patients how to evaluate their own somatic resources by being mindful of any body sensations, including tension, any feelings of discomfort, feelings of alignment in the spine, and feelings of relaxation or comfortable sensations. Assessing somatic resources includes determining if patients have the capacity to self-regulate or auto-regulate their arousal systems or if interactive regulation by the therapist is required. Ogden et al. (2006) drawing from Kurtz and Prestera (1976) suggest that the core is a "supportive pillar" and a "place inside" where the patient will "go for sustenance." Ogden et al., further explain:

> Somatic resources [or exercises] that involve awareness and movement of the core of the body (centering, grounding, breath, [and] alignment) provide a sense of internal physical and psychological stability and therefore support autoregulation. Somatic resources [or exercises] that develop awareness and movement of the periphery [of the body] (pushing away, reaching, [and] locomotion) tend to facilitate social skills and interactions with the world at large and support the capacity for interactive regulation. (p. 222)

Evaluating the core or parts of the body that hold it upright includes the spine, the intrinsic muscles of the thorax, the pelvis, and the small muscles that join the segments of the spine. The neck, head, and face are extensions of the core and therefore, are considered part of the core. Ogden et al. (2006) posit, "A strong core provides an internal

physical and psychological sense of stability, helping a person feel centered and strengthening an internal locus of control" (p. 271). Kurtz & Prestera (1976) posit:

> As the core becomes vitalized . . . emotional dependency and the constrictions of defensive attitudes yield to a sense of self, and open flexible interchange with others. [The patient] finds he no longer needs the external support or extrinsic rigidity to hold himself up. He can surrender these, and begin to feel the pleasure of . . . an integrated self. (p. 35)

Furthermore, Ogden et al. (2006) contend, "The intrinsic muscles of the core are sometimes considered 'being' muscles, whereas, the extrinsic muscles of the periphery, the arms and legs, are considered the 'doing' muscles" (p. 272). The therapist assesses how the patient executes both the core and periphery muscles and their "beliefs about self, others, and the world" (p. 282).

The therapist also assesses the patient's orienting movements of the face and neck for traumatic memory. For example, a patient may experience tightness in the neck or jaw as a defensive response to a traumatic memory. Since the sensation reflects an incomplete action that did not get to happen during a traumatic event, the patient may be directed to "'just stay with' the sensation" (Ogden, 2006, p. 258) and see what happens. Completing the action allows the body to discharge the energy and "bring calmness and peace in place of depletion and exhaustion" (p. 258).

The assessment also involves evaluating for incomplete actions with the therapist, noting the relationship between the core or spine, neck, and head, and the periphery, or the arms, and legs. While phase one of treatment will focus on resourcing the patient,

later, in phase three of treatment, a primary goal will be to discover the physical and mental tendencies that encourage the completion of seeking and approaching actions.

The Therapist's Role

During each step in the treatment process, the therapist will work collaboratively with the patient, ensuring a safe environment by working at a tolerable pace, body-tracking for any excess arousal that would marshal the patient's defensive subsystems and take them out of the window of tolerance. The therapist's role is defined by Ogden et al. (2006) as "an interactive psychobiological regulator for the client's dysregulated nervous system" (p. 206; see also Gil, 2009; Schore, 2003), also called the patient's "auxiliary cortex" by Diamond, Balvin, and Diamond, (1963), or in the words of Schore (2001), the therapist becomes an "affect regulator of the patient's dysregulated states in order to provide a growth-facilitating environment for the patient's immature affect-regulating structures" (p. 264). By the therapist functioning as the affect regulator or auxiliary cortex, combined with providing psychoeducation and thereby helping the patient recognize their triggers and learning to be mindful of their defensive subsystems, the patient gradually develops somatic resources and learns to self-monitor their own arousal.

Somatic resourcing is about expanding the patient's current movements and sensations repertoire; it is not about removing maladaptive coping strategies. Somatic resourcing begins with the therapist acknowledging the patient's rich variety of existing resources and validating how their defensive coping, perhaps utilizing immobilization, is a strength that allowed them to cope with traumatic experiences. This realization gives the patient hope and contributes to their stabilization. Developing new somatic resources,

or expanding existing resources, is a gradual sequencing process that is built over time, allowing the patient to "develop [a] . . . capacity to engage in purposeful and high-quality adaptive *actions* both mental and physical" (Steele et al., 2005, p. 14). With guidance from the therapist, the patient is slowly able to develop mindfulness, physical flexibility and choice of actions (Ogden et al., 2006, p. 275).

The therapist's objective is to help the patient transform their habitual familiar *reflexive* movements to organized *reflective* movements (Ogden et al., 2006, p. 289). A phase one treatment goal, stabilization, is achieved by helping patients to become aware of sensations in their body. It has been noted by Bakal (1999) and later by Ogden et al., 2006) that some patients have "alexisomia, the inability to put words to sensations" (p. 219). It has been suggested that these patients may benefit from being taught a "sensation vocabulary" (p. 219) to describe their sensations. Some patients may need to learn to differentiate body sensations from emotions and then be able to describe the sensation in language that is physical. For example, the patient may describe a body sensation saying "I feel tight or constricted" rather than with emotional words, such as "I feel angry." Some patients are also unable to differentiate traumatic activation of physical sensations with a cognitive belief. Rather than identify the physical sensation that has been triggered, they remain unaware of the physical sensation and instead formulate a belief that the world is not safe, for example, "I am a bad person and unworthy person" (p. 220).

Boundaries

During phase one of treatment, the patient learns to establish a sense of boundaries, safety, and self-care, which according to Herman (1992), "begins by focusing

on control of the body" (p. 160). Furthermore, Smith (1985) contends that physical tendencies are "a statement of . . . psychobiological history and current psychobiological functioning" (p. 70). Patients who believe they are bad, according to Ogden et al., (2006), may have the following physical tendencies:

> hunched shoulders, held breath, shortened neck muscles, and restricted movement [along with] . . . corresponding emotions of shame, anxiety, or hopelessness. The physical tendencies support the cognitive distortions and trauma based emotions and in turn, cognitive distortions and concomitant emotions manifest in physical tendencies that hinder the integration of core stability and peripheral movement. (p. 270)

A phase one task is for the patients to develop personal boundaries to protect themselves (Kepner, 1987, 1995; P. Levine, 1997; Macnaughton, 2004; Rosenberg, Rand, & Assay, 1989; Rothschild, 2000; Scaer, 2001, 2005).

Indeed, patients with DID and DDNOS who have had their physical and psychological integrity shattered by interpersonal boundary violations have a sense of heightened vulnerability. In sensorimotor psychotherapy the patient learns that they have a right to protect their body integrity with personal boundaries. Further, Ogden et al. (2006) state, "Reinstating a sense of somatic boundaries is facilitated by exploring actions involving the extremities, for example, [the actions of] pushing, kicking or walking away" (p. 226). Several trauma therapists agree that good boundaries are needed for healthy intimate relationships, but trauma survivors often reenact past boundaries violations (Briere, 1992; Chu, 1998; Harper & Steadman, 2003). Furthermore, Ogden et al. (2006) contend:

> Some patients, are "overboundaried" [and] . . . avoid contact with people, [while other patients] are "underboundaried" [and] . . . vulnerable to submissive behaviors. . . . [However] both boundary styles are defensive and therefore compete with adaptive responses to relational action systems. (p. 286)

In sensorimotor psychotherapy, the therapist is constantly exploring with the patient what feels right or good in their body, or perhaps even a neutral feeling, while at the same time trying to expand their resources, yet staying within the window of tolerance. This is achieved through a variety of physical exercises often using props such as pillows, or a doorframe to push against, or ankle weights to help with grounding exercises.

With gentle guidance by the therapist, patients learn to experience their physical body as a container for all dysregulated emotional physiological arousal. Ogden et al., (2006) write, "Containment is explored through mindful awareness of their body, skin, and muscles by [practicing] saying "No" and [saying] "Yes" (p. 230) and experiencing the different sensations in their body. Self-soothing exercises are explored to increase autoregulation by the therapist tracking the patient's spontaneous movements for self-soothing. For example, the therapist may notice the patient rocking back and forth and ask the patient to notice the sensations when rocking. When brought into awareness, and acknowledged, the action is developed and can be practiced as a resource outside of therapy. External self-soothing is also a somatic resource that the patient can practice at home, and includes taking warm baths, eating favorite foods, and listening to their favorite music, etc.

Therapeutic exercises might include the therapist modeling or demonstrating to the patient any current maladaptive actions or movements observed, then guiding the patient to use integrated and coordinated movements, which might include the periphery movement with their arms of pushing away, combined with the core movements of aligning the spine or standing tall, and making eye contact. According to Ogden et al., 2006), "Practicing these core and periphery movements increases integration and efficiency and the realization that previous actions might have given mixed messages in a social relationship and thus, maintains appropriate sexual boundaries" (pp. 290-291).

Moreover, those patients who demonstrate aggressive impulsive movements towards others and are unable to regulate their emotions may benefit from being able to identify the sensations that precede their violent acts by practicing centering, grounding, and breathing exercises. Centering exercises focus on the patient becoming aware of the alignment of their spine and then standing tall to lengthen the spine, giving them a more supportive stance. Grounding exercises include focusing the patient's awareness on their legs and feet, while feeling their body's weight connected to the ground. Breathing exercises are also useful. It has been noted that traumatized patients tend to hyperventilate or hypoventilate when aroused (P. Levine & Macnaughton, 2004). In sensorimotor psychotherapy patients are taught to be mindful of their breathing patterns and notice how inhaling increases their arousal, while exhaling has a calming effect. Ogden et al. (2006) and P. Levine and Macnaughton are in agreement that careful monitoring is necessary because breathing exercises may destabilize the patient if not done properly. Sensorimotor psychotherapy also teaches that learning to be mindful of

any shifts in physical sensations in the body provides a new somatic resource that is available to self-regulate arousal in stressful situations.

In summary, developing new resources in phase one of treatment takes intense conscious effort because humans are creatures of habit and we like to return to what is comfortable and familiar to us. Therefore, the patient will need to be guided by the therapist to execute new actions slowly, through sequencing, and staying within the window of tolerance. By virtue of repetition, executing the movements will become increasingly easier and faster until the correct actions become automatic (Ogden et al., 2006, p. 232). With a body that is more resourced, trauma patients will be able to experience a fuller capacity to stabilize and self-regulate. Additionally, somatic reprogramming will allow the patient to be able to "separate the present from the past and become less disrupted by his or her own arousal states and dysregulated defensive responses" (p. 232). Practicing somatic resources serves to stabilize arousal and reduce symptoms while preparing the patient to address traumatic memories in phase two.

Phase Two: Processing and Restoring

In phase two of treatment, *Processing Traumatic Memory and Restoring Acts of Triumph,* the primary goal is to explore all memory fragments and integrate them. Ogden et al. (2006) quote P. Janet (1925) as writing:

> The patients who are affected by traumatic memory have not been able to perform any of the actions characteristic of the state of triumph. . . . They are continually seeking this joy in action . . . which flees before them as they follow. (p. 247)

According to Ogden et al.:

> Because patients with DID typically suffer from amnesia related to early childhood trauma, these patients often do not have a coherent autobiographical narrative of their past, or they have an incomplete narrative. Instead of verbal memory, much of the patient's early memories are stored as sensory perceptions and physical symptoms without an organic basis. (p. 247)

Indeed, some patients enter therapy with the belief that if they could just remember their childhood, they could "fix" their problems themselves. Some patients have even undergone sodium amatol treatment believing "truth serum" would reveal the mystery of their childhood trauma only to be disappointed that new revelations were not brought forth. Ogden et al. (2006) posit, "sensorimotor psychotherapy is not memory retrieval, [rather] it is intended for resolution, not recollection" (p. 240). Moreover, Ogden et al. suggest that while some "recalled memories might provide insight and meaning" (p. 240), the therapist should avoid trying to validate or discount the absolute reality of the patient's memories that emerge during somatic interventions.

Furthermore, there are many risks for the patient involved in addressing traumatic memories, including retraumatization, further dissociation, reliving the traumatic tendencies, self-harm behaviors, and the inability to function in their daily lives at work or at home. To minimize the risks, the therapist must always keep in mind that accessing traumatic memories is conducted within the context of the patient's resources because a resourced patient feels safer and more competent. Therefore, the therapist is encouraged to review and practice with the patient the resourced skills that were installed or expanded in phase one treatment. Ogden et al. (2006) emphasize that prior to beginning

phase two treatment, a therapeutic alliance must be formed, and the patient must be able to demonstrate the "capacity for mindfulness, utilization of resources, staying in the here-and-now and ability to self-reflect" (p. 241). The challenge, and the process, is to "facilitate integrating fragments of memory from situationally accessible memory to verbally accessible memory" (p. 243). Ogden et al., drawing from Siegel (2007) write, "the intention is not just a verbal account of previously nonverbal memory, but also to bring nonverbal memory into a domain that is regulated by a different part of the brain" (p. 239).

Ogden et al., (2006) paraphrasing Brewin (2001) further explain that "elements of the trauma that are encoded in amygdala-dominated situationally accessible memory need to be exposed gradually to the hippocampally mediated verbally accessible memory system" (p. 239). Brewin further contends that this process will assist the hippocampus in accessing the entire autobiographical memory, putting the event(s) in context and thus, allowing the patient to be able to discriminate between the past and present times.

Furthermore, when facilitating memory work with patients with DID, it is important for the therapist and patient to collaborate to carefully plan the treatment interventions and have agreed-upon goals. The therapist's role is to pace the therapeutic process while monitoring the patient's arousal and somatic sensations. It has been suggested that therapists follow Kluft's (1993a) approach: "The slower we go, the faster we get there" (p. 42). If the patient becomes destabilized and unable to self-regulate, the therapist must return to phase one treatment and install additional resources, or expand existing resources. For example, Ogden et al. (2006) suggest if a hypoaroused patient begins to dissociate, the therapist may utilize grounding, centering, and physical

movement exercises and stop focusing on the content. It has been suggested that installing resources in the context of the traumatic memory may change how the traumatic memory is encoded.

Sensorimotor psychotherapy differs from traditional psychotherapy by discouraging abreaction and regression because they both involve a loss of mindfulness that impedes integration. Van der Hart, Steele, Boon, and Brown (1993) caution "abreaction or unconscious catharsis of overwhelming traumatic affects leads to states of hyperarousal and, at times, to complete psychological decompensation" (p. 165). Moreover, Ogden et al. (2006) state, "Although recalled memories may provide insight and meaning . . . therapists need to follow good judgment and decline to confirm or disconfirm memories that might emerge from somatic interventions" (p. 240). The primary concern for the therapist is to monitor the patient's arousal system and if narrating traumatic memories takes the patient out of the window of tolerance, they would redirect the patient to "drop the content" (p. 242) and focus solely on the body and its sensations until they feel stabilized. In this manner, the patient learns to self-regulate. Stabilization always takes priority over memory work.

Even after therapy progresses and the patient is able to construct a coherent narrative from memories, according to Ogden et al. (2006), they "may be left with visual images, olfactory and auditory intrusions, intense emotions, sensations, and maladaptive physical actions that are contained in implicit memory activated by both internal and external stimuli" (p. 236). Ogden et al., drawing from Siegel (1999), describe implicit memories as "somatic and affective *memory states* that are not accompanied by an internal sense that something from the past is being remembered" (p. 236). Ogden et al.

further state, "there are three forms of implicit memory: procedural, perceptual and emotional...and the traumatized person 'remembers' via all the avenues: through somatic action tendencies (procedural), sensory intrusions and sensations (perceptual), and emotional storms (emotional)" (p. 237). Techniques that resolve nonverbal trauma elicit and process all components of the trauma memory including "procedural, perceptual, and autonomic, motor, emotional, and cognitive" (p. 237). It is further pointed out that "of particular importance in a sensorimotor psychotherapy approach to traumatic memory is procedural memory" (p. 237), which is "expressed in behavioral acts independent of cognitive representational storage" (Sokolov, Spinks, Naatanen, & Heikki, 2002, p. 338).

In phase-two treatment, patients learn how to manage the amount of traumatic information that is released and processed at one time by mindfully focusing on the body and excluding awareness of emotions, cognitions, and the content of their verbal memory. In order to facilitate this process, the therapist will ask specific mindfulness questions to bring attention to precise details of the sensorimotor experience in the body. Some examples of mindfulness questions might be, "What sensation do you feel in your body as you remember this incident?" or "What happens when you make a fist?" Being mindful allows the patient to describe the experience of their internal organization without "going back there" (Ogden et al., 2006, p. 243).

Next, clients are asked to mindfully track (a top-down cognitive process) and report on the sequence of physical sensations and small movements (a sensorimotor sequencing process) as they progress through the body (Ogden et al., 2006, p. 253). The goal is to uncouple the traumatic emotion and narrative from the physical sensations and impulses without controlling the movements, thus allowing the patient to manage the

amount of information. The process of mindfully tracking detail by detail the involuntary physical movements and sensations that pertain primarily to unresolved automatic arousal, orienting, and defensive reactions expands the window of tolerance so that "cognitive and emotional elements of the memory can be carefully reintroduced, one at a time, into the therapy process" (p. 243). Ogden et al. recommend integrating traumatic memory by reactivating only a "sliver" of the memory at one time so that the patient stays within the window of tolerance. According to Brewin (2001), if the patient becomes hyperaroused, the frontal and hippocampal activity will become impaired preventing information from being transferred into the accessible memory system. However, Ogden et al. posit that to facilitate integration of nonverbal memory fragments the patient's arousal must be adequately evoked – pushing them close to the edge of the window of tolerance (p. 243).

When working with memory, the therapist will also help the patient explore what "peritraumatic" resources helped them to survive the past trauma(s). Peritraumatic responses, a term coined by Marmar, Weiss, Schlenger, Fairbanks, Jordan, Kulka, and Hough (1994), has been described by van der Kolk, McFarlane, and Weisaeth (1996) as the "Individual responses during the impact of a stressor" (p. 87). If they are unable to identity a peritraumatic resource, the therapist will help to install a new resource. One type of new resource that is beneficial is installed by having the patient recall elements of good memories and associating them with bodily sensations. This process intends to help a patient feel more competent by learning how to choose to orient towards positive thoughts and experiences. P. Levine (1997) suggests that guiding patients to oscillate between feeling competent and the traumatic reactions will help them to integrate

traumatic responses. Moreover, it has been suggested by Ogden et al. (2006) that, "installing somatic resources in the context of the traumatic memory may change how the traumatic memory is encoded" (p. 246). Further, Ogden et al. state, "When the patient is able to complete failed actions tendencies and feel 'triumph,' they are able to execute more adaptive mental actions and form an autobiographical story of their past" (p. 248). Moreover, Ogden et al. quoting P. Levine (2005) write, "When the implicit (procedural) memory is activated and completed somatically, an explicit narrative can be constructed, not the other way around" (p, 248).

The final result of phase-two treatment is "realization." Van der Hart, Steele, Boon, and Brown (1993) tell us that is the term used by Janet in the 1930s to describe "the formulation of a belief about what happened (the trauma), when it happened (in the past), and to whom it happened (to self). The trauma becomes personalized, relegated to the past, and takes on symbolic rather than sensorimotor properties" (p. 171). Janet also emphasized that realization requires not only a change in physical actions, but a change in how the patient thinks about and talks about their traumatic events.

In summary, in phase-two treatment the primary goal is to explore all memory fragments and integrate them from situationally accessible memory into verbally accessible memory. This must be done without retraumatizing the patient, which might cause them to further dissociate, to relive the traumatic tendencies, to inflict self-harm behaviors, or to lose their inability to function in daily life at work or at home.

Phase Three: Integration

In phase three, "Integration and Success in Normal Life," the final phase of sensorimotor psychotherapy treatment, the primary goal is to help patients lead a normal

life, which requires adequate integrative capacity. In phase one, the patients developed "somatic boundary resources to assure safety and regulate arousal" (Ogden et al., 2006, p. 296) with a focus on executing defensive movements of pushing away and on symptom reduction. In phase two, they focused on processing memories and mobilizing physical defenses via state-specific processing as they spontaneously emerged from somatic memories, thus replacing immobilizing defenses. While the resources and skills learned in both phases will be applied in phase three, the focus will shift to "self-development, adaptation to normal life and relationships" (p. 268). By the end of phase three, according to Ogden et al., patients should be able to: (a) sense the core of the bodies, integrate core and periphery movements, and complete the physical actions of seeking behavior that will allow them to form appropriate intimate relationships, (b) strengthen their mentalization or "mindfulness" (Siegel, 2007) skills and establish an internal locus of control, (c) change their mental actions of distorted cognitive beliefs, (d) express previously unexpressed emotions, (e) explore their attachment relationships including attachment to the perpetrator(s), (f) experience joy, triumph and pleasure; and finally, (g) identify new desires and explore new activities in daily life.

Integrated Movement Between the Core and Periphery

By the beginning of phase three, it is expected that the patient will have increased their integrative capacity and have developed a wider window of tolerance, thus allowing them to tolerate arousal and take appropriate risks. It is during this final phase that patients learn to sense the core of their bodies, including the "intrinsic muscles of the thorax, the pelvis, and the small muscles that join the segments of the spine and are responsible for holding the body upright" (Ogden et al., 2006, p. 271). Indeed, patients

with complex trauma symptoms, including those with DID and DDNOS, may have unresolved disorganized-disoriented attachment patterns that are reflected in their bodies with "a lack of integrated movement between core and periphery . . . [that result in] a body that is 'going in different directions,' as when proximity-seeking actions are combined with simultaneous avoidance or defensive actions" (p. 274). Therefore, an assessment of incomplete actions involves the therapist "noting the relationship between the spine, neck, head, arms, and legs" (p. 275). The goal of treatment is not to impose universal standards, but to help the patient become mindful of their body's sensations and physical actions, thus allowing them to develop physical flexibility and choice of actions.

Indeed, these contradictory physical actions would suggest that the patient is trying to reach out and connect to others, but their bodies impulsively tighten from past traumas causing then to simultaneously pull away. Kepner (1987) stated:

> If you want to reach out to others but restrain your arms at your side, you will have difficulty completing your need. If you wish to express joy in movement but are structurally bound up and muscularly inflexible in your movements, you cannot fully express your internal feeling. (p. 146)

Ogden et al. (2006) further suggest that these contradictory movements indicate that the patient may have "an aversion to emotional intimacy" (p. 276).

Furthermore, Ogden et al. (2006) assert that a strong core provides both a physical and psychological sense of stability allowing the patient to feel "centered." Treatment attempts "to integrate core and periphery, being and doing, [thus] enabling the patient to execute more adaptive actions that stem from a core sense of self" (p. 273). For example, utilizing centering exercises and guiding the patient to be mindful of sensations in their

spine enables them to connect to the core of their body resulting in their ability to attend to social cues, thus improving social relationships and changing distorted beliefs, such as "I am worthless and must hide" (p. 286).

Further, Smith (1985) posits, "Physical tendencies are "a statement of . . . psychobiological history and current psychobiological functioning" (p. 70). According to Ogden et al. (2006), patients who believe they are bad reveal distorted cognitions through their body language with "hunched shoulders, held breath, shortened neck muscles, and restricted movements. . . . [and with] corresponding emotions of shame, anxiety, or hopelessness. (p. 271). Becoming aware of their core state helps the patient become "deeply in touch with essential aspects of [their] own experience" (Fosha, 2000, p. 20), which in turn, helps them define their inner desires and "move in a more self-possessed manner" (Ogden et al., 2006, p. 271) to complete their goals.

Ogden et al., (2006) drawing from Lowen (1970) write:

> The traumatized person's attempts to seek pleasure through actions of approach and expansion, even when initiated from the core, are met by a collapse and loss of energy . . . the movements reflect a lack of integration between core and periphery and may be tense, jerky, uncoordinated, or weak. In contrast, pleasure is felt in "quiet and harmonious movements" . . . that are executed smoothly, from the core out to the periphery. (p. 295)

Moreover, Ogden et al. (2006) assert, "Assessing the degree of difficulty of a particular challenge [physical action] and evaluating its impact are key to successful integration of a new skill" (p. 278). The therapist is instructed to provide step-by-step instructions to the patient for executing challenging actions incrementally while being

cautious not to prematurely request an action that will lead to feelings of failure and discouragement. Furthermore, Ogden et al. quoting Janet (1919/1925) write: "previously incomplete or undeveloped actions both mental and physical, when practiced and completed, are the starting points of more sophisticated, creative, and complex tendencies" (p. 278).

The Ability to Mentalize

The ability to "mentalize," (Fonagy, Gergely, Jurist, & Target, 2002) or to be "mindful" or have "mindsight" (Siegel, 2007), is described by Ogden et al., (2006) as "the ability to be aware of our own internal experiences as different from that of others (personification), combined with the ability to 'resonate' with others in such a way that we can speculate about their motivation and intentions" (p. 284). The ability to focus awareness on the internal organization of one's experience versus their external experience restores, or strengthens, the patient's internal locus of control creating a feeling of safety, thus allowing the patient to "become aware of the present moment experience and experiment with different actions" (p. 172).

Moreover, because patients with histories of early childhood abuse tend to misinterpret social cues and thus, may not know how to respond appropriately in social situations, including in intimate relationships, as well as with parenting, the ability to mentalize is an important and useful skill to develop. Ogden et al. (2006) posit, "Misinterpretations and impaired communication reflects low integrative capacity" (p. 284). Being able to mentalize at the visceral and motor level allows the patient to make more adaptive responses. During phase-three of treatment the patient's ability to mentalize is strengthened by an assessment and awareness of the alignment of the

patient's spine. The therapist assesses the vertical alignment of the spine, or the patient's posture, and encourages appropriate alignment without using muscular compensation.

Ogden et al. (2006) postulate that centering exercises are especially helpful for patients with aggressive impulses, for example, violent inmates. A simple centering exercise requires having the patient place one hand on their heart and the other hand on their abdomen while being mindful of any shifts in sensations. Some patients have reported different results depending on which hand they place over their heart. This particular centering exercise is used to help violent inmates identify precursors to their violent actions. Centering exercises in general are believed to be able to help the patient develop an internal locus of control, orient and attend to social cues, improve relationships, and change distorted beliefs.

Distorted Cognitive Beliefs

Patients with complex trauma who have been severely abused as children often demonstrate habitual cognitive tendencies that do not resolve with traditional interpretive therapies (Steele, van der Hart, & Nijenhuis, 2005). Ogden et al. (2006) suggest that believing that they were abused because they were bad "may provide the client with a sense of internal locus of control and mitigate severe helplessness, [however,] this belief also prevents adaptive functioning in current life" (p. 263). Janoff-Bulman, Timko, and Carli (1985) are in agreement with Ogden et al. who argue that severe "trauma 'shatters' [the patient's] basic core beliefs [also called a working model in Bowlby's attachment theory] about self, others, and the world. . . . Learning new and more adaptive motor actions is accompanied by the patient changing their beliefs" (p. 269). A focus of phase-three treatment is to help the patient reorganize the experience(s), deal with their

meanings, and change the corresponding physical tendencies. Ogden et al. suggest, "Cognitive distorted beliefs are mirrored in the patient's body: in their posture, their orienting movements, their breath and body movements . . . [contributing to impaired] intimate relations, [impaired] parenting skills, employment [problems], and other activities" (p. 268). Kurtz (1990) states, "Becoming aware of cognitive distortions is a reflective process as well as an emotional one because these beliefs "come with [the] conviction and all the emotional charge that created them" (p. 117). Providing the patient with the confidence to believe that by reaching out they will not be hurt enables them to improve their relationships (Ogden et al., 2006, p. 279). For example, when patients learn that they can choose to set a boundary to be safe, and no longer believe that they are powerless, the distorted belief may change on its own.

Moreover, according to Ogden et al. (2006, p. 212) when patients combine a physical action with a psychological possibility, for example knowing that they have the ability to flee, they are able to stay within their window of tolerance and strengthen an interactive regulatory resource. Additionally, the realization of the trauma that was endured, along with a somatic and cognitive reorganization is a transformative experience that provides the patient with the resource needed to address emotions and grieve losses. A beautifully illustrated case example of Mary, a traumatized patient who appears to have DID, is provided by Ogden et al.

> "I'm two bodies in the same body doing two different things." As Mary experienced this dissociative compartmentalization somatically and processed the physical components of it (such as the impulse to fight her uncle), she experienced a deeper sense of grief associated with the abuse while remaining

> within the window of tolerance. Mary was able to process her cognitive distortions about herself and replace them with a sense of accomplishment in the realization of how she had actually been able to defend herself through the trauma with immobilizing defenses. As a result she experienced several compartmentalized parts of herself that submitted and froze. Her realization that a four-year old had to endure the abuse from an uncle ultimately resulted in a reorganization of the physical, emotional, and cognitive levels of her experience. (p. 264)

In phase three, the clinician explores with the patient the relationship between their core and periphery with an emphasis on "determining how this integration supports new meaning and adaptive action" (Ogden et al., 2006, p. 271). Furthermore, Ogden et al. posit that every physical action requires the "mental actions of perception, planning, initiation, or execution, and completion" (p. 291). They caution that when patients become hyperaroused they may return to familiar cognitive distortions. In fact, hyperarousal can also keep patients overly active and could result in their becoming workaholics. While clients are encouraged to trust their body by allowing impulsive movements to occur in order to complete the action tendencies, they are also directed to self-regulate and stay within the window of tolerance. The patient is able to self-regulate by becoming mindful of the sequence of mental and physical actions that comprise maladaptive tendencies.

Emotional Processing

Breuer and Freud (1895/1955), as quoted by Ogden et al., (2006) state, "Recollection without affect almost invariably produces no results" (p. 6. Therefore,

according to Ogden et al., emotions also need to be processed. In processing emotions, Ogden et al. tell us the intent is to reorganize "the memory through [the] hippocampally mediated and verbally accessible memory system" (p. 61). Care must be taken to help the patient remain in or near the window of tolerance to prevent abreaction and "to keep the verbal memory system and its attendant hippocampal machinery online" (p. 261). The authors further posit:

> Hyper or hypo-aroused patients are dissociated and cannot integrate the emotions or the fragments of the traumatic memory. . . . [The] trauma based emotions — what Janet called "vehement emotions" — involve powerful feelings of fear, terror, anger, shame, horror, and helplessness that emerge when an individual cannot respond adaptively to an inescapable threatening situation. (pp. 261-262)

Moreover, these vehement emotions manifest repetitively and may be experienced as anger when the patient's authentic feeling is fear or sadness thus reinforcing maladaptive tendencies that do not resolve in traditional therapy. Ogden et al. argue that these "trauma driven emotions do resolve with sensorimotor psychotherapy" (p. 263).

Attachment Relationships

In phase three, attachment relationships may be explored. Crittenden (1995) has described attachment as "patterns of mental processing of information based on cognition and affect to create models of reality" (p. 401). However, Ogden et al. (2006) argue:

> Attachment patterns are also held in place by chronic physical tendencies reflective of early attachment. Encoded as procedural memory, these patterns manifest as proximity-seeking, social engagement behavior (smiling, movement

toward, reaching out, eye contact) and defensive expressions (physical withdrawal, tension patterns, and hyper-or hypoarousal). (p. 47)

Indeed, patients with unresolved disorganized-disoriented insecure attachment patterns tend to be "unable to form constructive intimate relationships in adulthood" (Ogden et al., 2006, p. 275). Therefore, Ogden et al. suggest "the 'pinnacle of successful treatment' is demonstrated when the patient develops a high enough integrative capacity to form constructive intimate relationship" (p. 276). Furthermore, Ogden et al. contend patients demonstrate successful treatment by being able to "separate the past from the present" (p. 276). Furthermore, these types of attachment patterns suggest that the patient has a phobia of intimacy that must be treated on both a sensorimotor and cognitive level. Ogden et al. suggest that by understanding the different variations within each the therapist can help devise somatic interventions, as previously discussed, to repair the attachment disturbances pattern.

Pleasure

Janet (1919/1925) suggested that when treatment for trauma is successful the patient would demonstrate an increased capacity for pleasure "which we must do our utmost to obtain however difficult it may be" (p. 988). Some authors have suggested that trauma patients have little ability to experience pleasure (Luxenberg, Spinazzola, Hildalgo, Hunt, & van der Kolk, 2001; Luxenberg, Spinazzola, & van der Kolk, 2001; Migdow, 2003). In fact, some patients associate pleasure with pain and avoid experiencing pleasure for fear that it will bring humiliation or even more exploitation. Yet, other patients may seek pain and pleasure together, reenacting the abuse with sadomasochistic encounters (Ogden et al., 2006, p. 294). Migdow suggests that there is a

"fine line between pleasurable excitement and trauma arousal and [it is] difficult [for patients] to differentiate" (p. 5). Therefore, the patient may avoid all forms of excitation including: exploration, play, and sexuality. In addition, sexually abused patients may suffer from feelings of guilt for any pleasurable feelings experienced during the abuse. Furthermore, cognitive distortions may further limit the patient from pleasurable experiences (Kurtz, 1990; Migdow; Ogden et al., 2006). The experience of pleasure, which is related to action systems, is explained by neuroscientist Jaak Pankseep (1998), who states:

> A general scientific definition of the ineffable concept we call pleasure can start with the supposition that pleasure indicates something biologically useful... Useful stimuli are those that inform the brain of their potential to restore the body toward homeostatic equilibrium when it has deviated from its biologically dictated "set-point" level. Pleasure is nature's way of telling the brain that it is experiencing stimuli that are useful-events that support the organism's survival by helping to rectify biological imbalance. (p. 182)

Damasio (1999) and Ogden et al. (2006) hold similar views about pleasure. Ogden et al. state, "Pleasure is a biological design for adaptive purposes and is commonly initiated to correct an imbalance, for example, low blood sugar" (p. 294). Damasio further explains:

> Pleasure is . . . about forethought. It is related to the clever anticipation of what can be done not to have a problem. . . . Pleasure is aligned with reward and is associated with behaviors such as seeking and approaching. . . . Pain is aligned with punishment and associated with withdrawal or freezing. . . . Punishment

> causes organisms to close themselves in freezing and withdrawing from the surroundings. . . . Reward causes organisms to open themselves up and toward their environment, approaching it, searching it, and by doing so increasing both their opportunity of survival and their vulnerability. (p. 78)

Migdow (2003) further posits, "The first developmental task in the evolution of capacity for pleasure is awareness of sensation" (p. 19). The challenge for patients, according to Ogden et al. (2006), is for them "to become aware of their bodies' pleasurable sensations . . . [by teaching them the] skills of discerning what feels good to them and [helping them] to discover the joy of achievement and to tolerate frustration" (p. 296). The goal of therapy is to help the patient be able to tolerate positive affect while resisting trauma related tendencies. For example, Ogden et al. suggest offering the client support and encouragement to find pleasure in bodily sensations incrementally during sessions by learning to focus on the following: "color, smells, sounds, [and] sensations on the skin from textures, air current, and temperature" (p. 297). By tracking the patient's body language, such as a slight smile, deep breathing, or integrated movements with the patient, and pointing out to the patient what appears to be positive affect, the clinician further helps the patient identify movements and postures that are pleasurable or at least not uncomfortable (pp. 297-298). And finally, Herman (1992) points out:

> The best indices of resolution are the survivor's restored capacity to take pleasure in her life and to engage fully in relationship with others. She has become more interested in the present than the past, more apt to approach the world with praise and awe than with fear. (p. 212)

Daily Life Activities

In summary, during this final phase of sensorimotor psychotherapy treatment it is expected that the patient will have developed a high enough integrative capacity to live a normal life with the ability to seek intimate relationships and experience pleasure. Phase three provides an opportunity for the patient to identify which daily activities are meaningful to him or her (Brown, Scheflin, & Hammond, 1998; Ogden et al., 2006), develop new interests, and perhaps discover previously unrecognized talents. Even though the patient's integrative capacity has been raised, trying unfamiliar activities brings with it new sensations that may be misinterpreted by the patient as danger signals. While contemplating the new activity, the therapist and patient will collaboratively track the new experience "in both the core of the patient's body, their thoughts, emotions, sensations, movements and sensory perceptions" (Ogden et al., p. 280) to determine if the response is a habitual archaic response to trauma, or a new, novel response that naturally is exciting, and thus expected to increase arousal. Together they will explore the cost-benefit ratio and determine if the response is a habituated archaic trauma response, or if the response feels empowering and, therefore, will contribute to furthering the development of the action systems of play or sexuality. Ogden et al. posit: "As new physical actions are evoked memories, emotions, and new insights emerge and are addressed. As the therapist gently guides this process, there is a flow of sensory and motor information carried to the patient's mind" (p. 280). Juhan (1987) states, "It is then the mind of the client that does the 'fixing' — the appropriate adjustment of postures (p. xxix).

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) techniques can be applied to the treatment of DID, DDNOS, and ego state work with adaptations designed specifically for working with patients with complex trauma. An adaptive version of EMDR used as an adjunctive method of treatment utilizing Alternating Bilateral Stimulation (ABS) is used to accelerate "communication across dissociative boundaries . . . and for maximizing learning among parts of the mind" (Twombly, 2000, p. 62). Using EMDR with this population is not, however, without liability. Using EMDR incorrectly and without adaptations could cause the patient to decompensate.

For clarity, Twombly (2000) prefers to use the terms "part" or "part of the mind" rather than "alter" and "personality." The part(s) of the patient who has responsibility for "daily activities, such as going to work, are referred to as the "daily-life team" to remind the patient that "perceived separateness is more of an illusion than reality" (p. 62).

Treating patients with complex trauma, what Kluft (1993a) refers to as "multiple reality disorder," utilizing EMDR adaptations requires that the clinician have expertise in both DID and EMDR. The standard protocol, according to Shapiro's (1995) EMDR treatment model as stated by Twombly (2000), "tries to identify and desensitize whatever associates to trauma exist" (p. 62). In contrast, the adapted EMDR protocol to be followed with patients with complex trauma "takes care not to overwhelm them with affect laden material" (Lazrove & Fine, 1996, p. 290).

Twombly (2000) provides a set of EMDR adaptations developed from personal experience in working with patients with DID and integrates them with Kluft's (1999) nine-stages of treatment summarized as follows:

> (1) Establish the psychotherapy, (2) preliminary interventions, (3) history gathering and mapping, (4) metabolism of the trauma, (5) moving toward integration/resolution, (6) integration, resolution, (7) learning new coping skills, (8) solidification of gains and working through, and (9) follow-up. (p. 62)

Prior to using EMDR adaptations, Twombly (2000) advises that Kluft's (1999) first stage of treatment, *establish the psychotherapy*, be accomplished to prevent a feeling of intrusiveness from the EMDR techniques. In Kluft's second stage, *preliminary interventions*, the clinician begins to work with the parts that are available by contracting with them for safety and cooperation. The clinician fosters communication and a working alliance among the parts as well as teaching the patient techniques for grounding, self-soothing, coping, and containment. As the patient learns coping skills, the clinician installs and solidifies the learning using short sets of ABS, "three to five pairs of alternating stimuli," (Twombly, p. 63). Long sets of ABS are avoided to prevent inadvertently activating traumatic material. The learned coping skills are then communicated by the "host" part to other ego states or parts, but only if they are willing to accept them.

Standard Resource Development and Installation (RDI), another helpful EMDR protocol, "refers to a set of EMDR related protocols which focus exclusively on strengthening resources in positive memory networks [while avoiding] stimulating dysfunctional memory networks" (Twombly, 2000, p. 64). Following RDI, any developed resources can be communicated to other accepting parts with the ABS technique.

Twombly (2000) designed three specific techniques to be used in conjunction with ABS for patients who have a dissociative disorder. Their purpose is to help "facilitate communication and cooperation, decrease anxiety, increase grounding in the present, and help decrease negative transference. . . . [They are] Installation of Current Time and Life Orientations, Height Orientation, and Installation of the Therapist and the Therapist's Office" (p. 64).

The timing of utilizing these techniques is critically important because they are designed to increase the internal system's knowledge and awareness of the present, which inherently can cause distress. Lowenstein (1993), as quoted by Twombly (2000) has pointed out: "The selectively focused attention of the MPD [DID] patient often helps to maintain dissociation so intensely that any movement toward greater awareness may be experienced as disphoric" (p. 64). Lowenstein cautions the clinician to postpone using this technique should the patient experience distress.

Technique No. 1: Installation and Transmission of Current Time and Life Orientation

This technique is used by Twombly (2000, p. 64) to decrease the patient's anxiety and increase their ability to recognize the past from the present. Twombly will orient the host and/or other oriented parts by discussing with them how they know certain information. For example, she will ask *how* the patient knows what year it is rather than just *what* year it is. This line of inquiry helps the patient differentiate the past from the present. After formulating a verbal list of known facts about their current life, the patient is asked to visualize the list in still pictures and video, which helps to communicate the information to non-verbal parts. This information is then installed with the ABS

technique. During the installation, the therapist can insert missed details not verbalized by the patient's narrative and add additional information if it comes up. The clinician will ask the parts to be open to accepting the information without requiring them to believe the information. Homework will be assigned to have the parts check out the information with the host part(s) and report on the results discussed in the next session.

Patients are encouraged to try using bilateral tapping, walking, and bilateral movement, (e.g. shifting their weight back and forth much like a mother does when holding a fussy infant) when they are triggered by reminders of their past that are distressing to them. However, this should not be tried if the patient is poorly grounded or lacks ego parts that could help other parts to reasonably identify facts about the present.

Technique No. 2: Height Orientation

Height orientation has to do with space or a patient's personal physical size. Child parts may experience themselves as being very little in size. In fact, sometimes the patient perceives himself or herself as unable to reach something from a tall shelf due to his or her perceived small size. Orientation to height may help the patient differentiate the past from the present. Twombly (2000, p. 67) will ask a child part to volunteer to experiment and be co-conscious with an adult part and try to reach something from a high place. If the patient is able to reach the high place, the new knowledge is installed with ABS and communicated to the other internal parts in the system, again, but only if the other parts are willing to accept the new knowledge. Words of caution, this does not always work with patients afraid to grow up. Also, the part's perceived age does not necessarily change with acknowledgement of their new perceived height. Thus, the host or a more

mature, perhaps older part, may have to set limits and not allow a child part to perform tasks that they are unable to manage; for example, driving a car.

Technique No. 3: Installing Therapist and Therapist's Office, Maintaining Duality

The technique of *Installing Therapist and Therapist's Office* promotes cooperation between the clinician and the patient's internal system. It also helps the patient maintain duality, a standard part of Shapiro's (1995) EMDR practice, whereby the patient maintains an orientation to the present and the past simultaneously during trauma processing. Additionally, this technique helps to minimize negative transference, which Twombly (2000), quoting Lowenstein (1993) writes: "concerns about the therapist's trustworthiness, inherent dangerousness, and potential abusiveness" (p. 69). The ABS facilitates communication among parts and all "protective" parts are invited to continually monitor the therapist for the above concerns. This adaptive process is also used to prepare patients to process traumatic material.

To prepare patients in a safe and controlled manner to process traumatic material, Twombly (2000) agrees with van der Hart and Steele (2000), that it is best to use "a modulated and controlled process" (p. 69). Once the patient has established a relationship with the clinician and is equally experienced with the clinician's office (patients need to feel safe in the therapeutic environment), Twombly will have the patient list factual information about the appearance of the office, for example, list the date by showing the patient a current calendar; list safety oriented information, for example, reminding the patient that no past abuse has happened to them in the clinician's office, and no future abuse will be allowed to harm them in the therapist's office. Finally, list significant interactions that have taken place between the therapist and the patient, for example, how

the therapist has responded empathically to him in the past. The listed information is installed and the knowledge of the present is communicated to any parts living in the past that are willing to accept it.

The goal of Twombly's (2000) structured format "is to teach clients to have control during the processing of traumatic material, and to enhance the ability of parts to work together" (p. 71). This format also combines adaptations of EMDR with hypnotic techniques, to be discussed below, to help create a feeling of safety and of being in control by allowing the patient to start and stop the processing of traumatic material. Additionally, it limits the number of parts involved in the processing at one time. Thus, parts that must maintain stability in their daily life are protected from the impact of trauma work. Indeed, over time, affect from the trauma work becomes diluted before it reaches "daily-life" parts (p. 71).

Work on processing traumatic material begins with the therapist and patient dyad choosing a targeted area of material of a lesser traumatic nature that they believe will not be disruptive to the daily-life parts. The target area is then "fractionated;" a method developed by Kluft (1989) and expanded by Fine (1991), which deconstructs the material into smaller, more manageable amounts of affect and sensation. Parts that are not involved in the process may be asked to go to their "safe place" and using autohypnotic suggestion, raise walls to protect themselves. Following standard EMDR protocol, along with choosing a goal, the "host" part is invited to identify a negative and positive cognition. During this process, any additional resources that are needed are developed and installed with ABS. It is important to note that the patient is continuously reminded

throughout the process that they are always in control and can start and stop the process as they choose.

Following the installation, guided imagery is utilized to help the patient practice their new skill of being in control. For example, the patient may be guided by the therapist to imagine that they are watching the trauma on a TV screen and that they are in control and able to turn the picture on and off at will. Imagery also allows the patient the options of turning the volume up and down, or setting it to mute; seeing a picture-within-a-picture (PIP), similar to watching two TV shows at one time; making the picture smaller or larger; or projecting it near or far. The patient is then invited to imagine a picture of the therapist and the therapist's office on the full TV screen followed by an invitation to imagine a PIP of a mild trauma holding the image for two seconds at a time before turning off the PIP. When the patient is ready and has granted permission, the picture of the full screen with the clinician and her office is installed with ABS. This sequence is practiced multiple times with each PIP period lasting for longer periods of time until the patient feels confident of their ability to use the technique and stay in control during trauma processing. At the end of therapy hour, parts are invited to return from their safe-place and provide feedback as needed.

As each targeted area of traumatic material is processed, groups of parts, or pairs of parts, often, but not always, integrate. The change is acknowledged and the internal system's adjustment to the change is discussed. Some of the parts who have completed the trauma work may become effective at helping other parts work on their trauma experiences.

Twombly (2000) posits that as the traumatic material is processed, dissociative boundaries are no longer needed and integration may occur spontaneously or can be assisted by the clinician. Typically, this "process is gradual with groups of parts integrating over time rather than all at once" (p. 78). During this stage of integration, parts can be invited "to review their life from their earliest memories to the present" (p. 79). If any new charged traumatic material is discovered it can be processed if it is negative, and installed if it is positive.

In summary, EMDR with adaptations can be integrated with other phase-oriented treatment with patients with complex trauma, especially with DID and DDNOS. It is used to facilitate communication across dissociative boundaries and to strengthen resources and coping skills. And finally, EMDR can be used to help patients adjust to life without dissociative defenses.

Adjunctive Techniques of Hypnosis and Guided Imagery

Since the 19th century, hypnosis has been utilized by clinicians as an adjunctive technique to facilitate the treatment of psychotherapy with patients who dissociate and who may be diagnosed with dissociative identity disorder, previously multiple personality disorder (Ellenberger, 1970). It is important to note, in the literature the term "hypnosis" is used to mean both a *therapeutic technique* that is done to the patient, as well as a *defense mechanism* that is used by the patient. Additionally, when referring to a defense mechanism, the terms *hypnosis, autohypnosis, and dissociation* are often used interchangeably. It would be useful for the clinician to understand how the patient utilizes autohypnosis as a successful defense mechanism to promote survival.

Autohypnosis as a Defense Mechanism.

Charcot and Janet first popularized the theory of autohypnosis over a century ago. According to their theory, some patients have a predisposition to dissociate due to a weak nervous system, or due to trauma. Furthermore, their theory posited "hypnosis resulted in dissociation, the separation of client's ideations" (Sapp, 2000, p. 29). A similar definition offered by Cardena defines the hypnotic phenomena of dissociation as "two or more mental processes not integrated. For example, when a patient dissociates, they can detach from their environment or from their body" (p. 21).

A neo-dissociation theory, a modification of Charcot and Janet's theory, was posited by Hilgard (1994). Sapp (2000) explains that Hilgard's information processing concept suggests that hypnosis is due to "a combination of dissociation and an amnesic barrier among dissociated subsystems . . . patients experience hypnosis as involuntary and nonvolitional" (p. 30). Hilgard's theory also views "behavior as arranged in a hierarchical series of subsystems that produce habitual actions and sequences . . . controlled by the executive ego" (p. 30). Moreover, during dissociation, the patient's "sensations, memories, and volitions may not be integrated; hence these mental processes are dissociated" (p. 21).

Sapp (2000) tells us that Woody and Bowers (1994) questioned Hilgard's theory of an amnesic-barrier, and in contrast, presented a dissociated control theory of hypnosis in their 1994 study. According to Sapp, their theory defined hypnosis as "the dissociation of cognitive and behavior subsystems from the executive ego's control and not a separation of consciousness" (p. 31). From this perspective, according to Sapp, dissociation is the result of a "frontal lobe dysfunction or inhibition. Hence, frontal lobe

dysfunction is brought about through [auto] hypnosis and an altered state of consciousness" (p. 31).

Helen and John Watkins (1993), who developed Ego-State therapy, offer another explanation for dissociation. Their theory postulates that all humans develop their personalities through the process of integration, which consists of "regrouping of experiential elements to allow us to develop generalizations and evolve higher-level concepts" (p. 277). Thus, a child learns to differentiate between caring and hostile individuals to increase their chance of survival. Watkins and Watkins contend the process of differentiation helps us to make finer discriminations and that a moderate amount of differentiation is more adaptive. However, according to Watkins and Watkins, the process proceeds on a continuum with an extreme amount of differentiation becoming increasingly maladaptive until the level of dissociation is reached, "which may involve the segmentation [or fragmentation] of the mind into ego states of which may lead to the development of multiple personality disorder [DID]" (p. 278).

Sapp (2000) acknowledges Gill and Brenman's (1959) conviction that "the client's ego controls hypnotic regression" (p. 35). They believed that "during hypnosis a portion of the client's ego regresses and searches for derivatives of a regressed state" (p. 35). However, during this process, "the ego does not lose contact with reality" (p. 35). Sapp tells us that Schilder holds a similar view of adaptive regression and quotes him as saying, "only a part of the ego becomes involved during hypnosis, and a part of the ego maintains in contact with the external world" (p. 35).

Sapp (2000) lists the phenomena of hypnosis as including, but not limited to: "absorption, dissociation, repression, suppression, catalepsy, amnesia and hyperamensia,

analgesia and anesthesia, hyperesthesia, ideomotor and ideosensory exploration, somnambulism, hallucinations, age regression, age progression and time distortion, depersonalization and derealization" (p. 20). Indeed, it is the phenomena of dissociation and regression that gives clinicians the potential to treat a variety of disorders with hypnosis in which the major feature is dissociation, such as dissociative identity disorder (DID), borderline personality disorder, somatoform disorder, and posttraumatic stress disorder (PTSD) (p. 37).

Hypnosis as a Technique

While the definition of hypnosis as a technique has been expanded upon by many theorists since the 19th century, Sapp (2000) provides us with the contemporary definition of hypnosis by The American Psychological Association (APA) Division 30 (Psychological Hypnosis), which states, "hypnosis is an interpersonal relationship between a client and a mental health professional in which the mental health professional offers suggestions to the client that can produce psychophysiological responses" (p. 19). According to the ISSD (2005) guidelines for treating adults with dissociative disorders, hypnotic techniques can be used for the following reasons:

> Ego-strengthening, symptom exploration and relief, anxiety relief, accessing alternate identities and restoring adult identities when immature or dysfunctional identities are in control at a session's end, containment of flashbacks, containment and control of spontaneous and facilitated expressions of strong feelings and abreactions, stabilizing the patient or particular identities between sessions, exploration and relief of painful somatic expressions of traumatic materials, restabilizing and restoring mastery, cognitive rehearsal and skill building,

> facilitating communication within the alternate identity system, and in fusion rituals. (p. 120)

However, the use of hypnotic technique and the idea of the clinician offering the patient suggestions are highly controversial issues. Some clinical investigators (Kampman, 1976) and scientific investigators (Spanos, Weekes, & Bertrand, 1985) blame the clinician for creating the patient's alter personalities by implanting suggestions. These clinical investigators further believe that "DID/MPD is an iatrogenic artifact, limited to distribution to those areas in which clinicians evoke these artifacts on a regular basis" (Kluft, 1995, p. 356). In fact, Kluft, drawing from Fahy (1988), described DID/MPD as a "North American culture-bound condition [and suggested that the enthusiastic clinician] creates cues and expectations that explicitly or implicitly induce the patient to manifest its characteristics" (p. 356).

Indeed, just are there is concern today about creating an iatrogenic artifact, in the 19th century there was concern with the idea that "hypnotic phenomena were created by unconscious suggestions made by the therapist or by the hypnosis" (Alvarado, 1991, p. 36). These charges were primarily against Charcot and his work with patients at the Salpetriere in France. In a critique by Alex Munthe (1929, p. 302) it was suggested that the patients that Charcot presented on stage had been given posthypnotic suggestions by their clinicians, or they were imitating the behavior of other patients. In fact, some physicians suggested the patients were demonstrating "unconscious imitation of what is expected" (Carpenter, 1884, p. 619). However, the historical literature on multiple personalities debates these issues. Indeed, Pierre Janet, as interpreted by Alvarado, (1991,

p. 37) had warned therapists in the 1880s that once a personality is named it can become more life-like. Furthermore, William James (1890) suggested:

> It is very easy in the ordinary hypnotic subject to suggest during trance the appearance of a secondary personage. . . . One has . . . to be on one's guard in this matter against confounding naturally double persons who are simply temporarily endowed with the belief that they must play the part of being double. (p. 475)

Contemporary literature suggests two views of iatrogenesis. The first view is the artificial creation of dissociative phenomena or other personalities. In this view, the clinician's intervention creates the dissociative phenomena, or multiple personalities. An example is Morton Prince's Sally Beauchamp case, which according to Kenny (1986), suggests that clinicians unconsciously conspired with their patients to create disorders. The second view is that the therapist shapes, but does not create, the alter personalities and their behavior. Rather, they are believed to be affected by the context in which they are presented regardless of their etiology (Alvarado, 1991, p. 37).

Another area of great controversy is the false memory syndrome (promoted by Elizabeth Loftus) that surrounds the use of hypnosis to explore amnesia. Those clinicians who argue against the use of hypnosis to facilitate memory retrieval believe it will increase the risk of the patient reporting fantasy as actual historical events (ISSD, 2005, p. 121). For example, some patients may blame their parent for abusing them due to a memory suggested by the clinician rather than a factual memory. Indeed, studies have found that some DID patients may be highly "fantasy-prone" (Lynn, Rhue, & Green, 1988), while other studies have reported patients to be moderately fantasy prone (Williams, Loewenstein, & Gleaves, 2004). To minimize the risk, clinicians are cautioned

to avoid the use of leading questions and hints that may alter the details of the recalled memories. Other clinicians argue against the use of hypnosis to request alter identities to make themselves available, promoting inner dialogues among the alters, the use of Fraser's (2003) "Dissociative Table" technique, and even against the use of other allied techniques.

In contrast, some experts, such as Kluft, who support the use of hypnosis for recovered memories, cite cases where the information has later been confirmed to be true (personal communication, ISSTD Conference, Chicago, November 2008). The *Guidelines for Treating Dissociative Identity Disorder in Adults* (2005) also argue that some form of hypnosis "inevitably takes place in therapeutic work with this highly hypnotizable group of patients" (p. 121). Sapp (2000) presents Kirsch and Lynn's (1995) argument that it is "a misconception that hypnotized clients are merely complying with hypnotic suggestions" (p. 27). In fact, they believe just the opposite, that the clients are the "generators of hypnotic behaviors" (p. 27).

Spiegel (1989) offers several reasons why hypnosis can be helpful in the psychotherapeutic process. First of all, any trauma that causes threat to life and bodily integrity can result in the loss of physical and/or emotional control to the victim. Dissociation is a defense mechanism employed by trauma victims to "diminish the immediate and disorganizing impact of sexual assault and physical violence [and] is a hypnotic phenomena that is intrinsic to the experience of sexual abuse and to symptoms of PTSD" (p. 295). Paradoxically, Spiegel posits the use of hypnosis helps to "control traumatic memories and their associated affect" (p. 295). In fact, according to Spiegel, hypnosis is a controlled dissociation utilized with formal instructions that teaches patients

that they have the ability to control access to the memories and can turn them off at will. It also provides boundaries to the experience. Additionally, just as hypnosis starts with formal instructions, it is also terminated with formal instructions. Spiegel contends, "hypnotic technique makes it seem less overwhelming" (p. 300).

Furthermore, Spiegel (1989) suggests telling a patient how to mull over the details of an assault to make it therapeutically productive rather than mulling over it mindlessly, thus allowing the patient to move on (p. 301). In fact, shutting off angry feelings toward the perpetrator "reinforces the victim's sense of being unacceptable and isolated . . . [and] strengthens dissociative and other defenses" (p. 302). Indeed, there is less controversy over the use of hypnosis for "supportive and ego strengthening interventions, resolving crisis, stabilization, and promoting integration" (Sapp, 2000, p. 49).

In contrast, Sapp (2000) cautions, that while "hypnosis can increase the capacity of memory, called hyperamensia, . . . memories can be inaccurate because of suggestions from a hypnotist. In addition, memory is always a reconstructive process that is influenced by the context" (p. 23).

Goals of Hypnosis

The goals of hypnotic treatment, according to Sapp (2000), "are similar to that of other fusion procedures; that is, the integration or partial integration of the client's cognitive, affective, behavioral, and so on experiences to the maximum extent possible" (p. 54). A slightly different version is provided by Horevitz (1996) who described the goal of treatment as the integration of cognitive function, affective experiences, a sense of personal history, and the personal environment, and not the fusion or integration of separate personalities. Sapp posits, "From a clinical standpoint, the integration of

cognitive, emotive, and behavioral experiences is more practical" (p. 51). Wilbur (1984) and Kluft (1987) found that a minority of clients with DID who have ego strength can undergo psychoanalysis and forego hypnosis; however, Kluft contends that dissociative identity disorder is a "disease of hiddenness" and recommends combining psychoanalytic psychotherapy with hypnosis for the majority of patients.

Moreover, according to Spiegel (1989), "the task of psychotherapy is examining and making bearable to consciousness these hidden or warded-off states of memories. Patients must face and grieve these memories" (p. 299). Spiegel supports the use of hypnotic techniques to couple the memory of the trauma with the recognition of the strengths they were able to mobilize to service, thus allowing the patient to restructure their perception of themselves in a positive manner rather than a degraded view of themselves.

Schools of Hypnosis.

Traditional hypnosis is based on direct suggestions such as "you will stop smoking" or "you must stop overeating" (Sapp, 2000, p. 27). In contrast, Ericksonian hypnosis is a collaborative model with a permissive style. For example, the clinician uses verbs such as "you may stop smoking" or you "can stop overeating" (p. 27). Another feature of Ericksonian clinicians is their belief in the client's "internal resources and inherent capacities for change" (p. 28). From an Ericksonian perspective, "hypnosis is viewed as an altered state characterized by muscle relaxation, reduced blood pressure and a slower breathing rate" (p. 27). Erickson, according to Sapp (p. 27), "viewed the unconscious as a reservoir of knowledge that can aid the client toward therapeutic change" (p. 27). Furthermore, Sapp highlights Zeig and Rennick's (1991) view stating,

"Ericksonian hypnosis is a communication model where formal trance or inductions may not be employed" (p. 28).

Traumatic Transference

Transference is also an important consideration when using hypnotic technique to treat patients with complex trauma or DID and DDNOS (Spiegel, 1989, p. 301). The intensity of the hypnotic reliving of a traumatic event provides an opportunity for the clinician to bear strong affects. When the clinician can tolerate the affects, the patient can feel understood and accepted and not judged and rejected.

Furthermore, the clinician who is trying to be supportive of the patient may experience the transference of angry emotions directed toward the perpetrator in the relationship. Spiegel (1989) contends these feelings must be acknowledged and worked through in the therapy. Indeed, failure to acknowledge the transference feelings may contribute to the patient's sense of feeling unaccepted and strengthen the dissociative defenses as the traumatic material will feel even more terrifying.

In summary, hypnosis is a state of intensely focused attention, similar to the state experienced at the time of the traumatic event(s). Therefore, hypnosis provides a direct means to access the dissociated memories, while teaching the patient how to stay in control and avoid certain memories until they are confident that they have control to modulate or stop the memories. Additionally, hypnosis can help the patient restructure their perspective of the traumatic memories, balancing their feelings of helplessness and fear with a sense of courage and wisdom that allowed them to survive. It also helps the patient to regain a sense of personal continuity. And finally, DID experts generally agree

that hypnotic techniques could be useful both in sessions and between sessions (ISSD, 2005, p. 120).

As with other specialized techniques, practicing in an ethical manner suggests that prior to the use of hypnosis the therapist will review with the patient the risks, benefits, and controversies concerning recalled trauma memories and obtain full informed consent from the patient. Further, according to the American Society of Clinical Hypnosis, the therapist should be knowledgeable of the statutes and judicial rulings of the jurisdiction in which they practice because information obtained under hypnosis may not be permissible testimony in some legal settings (ISSD, 2005, p. 121).

Guided Imagery With Hypnosis

While there are many interventions that can help the patient reach the goal of integration, Lemke proposes the use of imagery, a common technique utilized in hypnosis. Lemke (2007) argues that since patients with DID, "are often in an altered state of consciousness . . . they are great candidates for hypnotic techniques such as imagery" (p. 55). Furthermore, drawing from Frischolz, Kipman, Braun, and Sachs, Lemke states, "DID patients often have high levels of hypnotizability" (p. 55), making them highly responsive to these types of interventions. Lemke also acknowledges Kluft and asserts that patients with DID have vivid perceptions of their ego-states, also called parts or alters by other authors, that may include "visual images of how they look and are different from one another in size, age, and overall appearance; different voice tones and or language utilized; different mannerisms and demeanor; and even different names" (p. 57). Furthermore, patients with DID often feel like they are different people rather than

just different parts of the same personality. Lemke further quotes Kluft in describing this process:

> The patient forms and autohypnotically envisions an illusory embodiment of an identity that could manage the adaptation that is believed to be real, and the mind undergoes a cognitive restructuring that accepts and interprets what is believed to be real as real, and makes it possible to act as if is were real. (p. 57)

Because the perceived illusions seem so real and are frightening, the patient lives in a constant state of anxiety. Following an ISSD recommended phase-oriented treatment approach, and stabilizing the patient in phase one, Lemke will introduce internal imagery to deal with the fear and anxiety. She will educate the traumatized ego states that the scary introjects are not the perpetrators, even if they have been given the same name as the real perpetrators, but were created internally to protect the system and to help keep the secrets in the only way they know how.

Prior to initiating imagery to transform and change the fear of the scary introjects, Lemke (2007) suggests that all of the "introjects ego-states must agree with any changes suggested" (p. 60). According to Watkins and Watkins (1993), the scary introjects can be a traumatized child mimicking the behavior of an abusive parental or adult figure. Once the ego states are in agreement, Lemke may suggest that the introjects collaborate and chose a name change that has a more friendly symbolic meaning and one that will not remind the internal family system of an abuser. Patients have reported that the name changes make the system less afraid.

Another imagery technique utilized by Lemke (2007) is the "meeting room," (p. 63) an adaptation of Fraser's (2003) dissociative table technique. Lemke suggests that

when it is too scary for the traumatized ego states to be in the same room with scary ego states, imagery is used to put distance between them. This is accomplished by separating the ego states into different rooms with temporary walls thus, allowing the frightened ego states a safe place to feel protected while they calm down enough to begin working with them. At an appropriate time, and at a manageable pace, the walls can come down. Lemke suggests that a similar technique that is utilized in guided imagery is Daniel Brown's "hypnotic bubble," which helps to provide a feeling of safe boundaries.

Lemke (2007) contends that just as hypnosis is used to change the intensity of pain, it is possible to change the perception of the introjects' ego-state with hypnotic and/or imagery suggestions. A useful technique proposed by Lemke to change the perception of the scary introjects is to have the patient draw the internal imagery of the scary ego states, but with less scary features

Shusta-Hochberg (2004) uses a guided imagery technique she calls "the window-blind," which involves visualization of one's other ego-states. Using the window-blind technique:

> The patient is asked to visualize a wall with a window. The blinds are drawn. She is told that other parts of the system are on the other side. The patient is asked to twist the wand of the blind slightly and look through and report what she sees" (p. 18). Shusta-Hochberg utilizes this technique to assist patients in accepting their diagnosis and viewing dissociation more objectively. (p. 18)

In summary, imagery, the most common hypnotic technique used by the experts in the field of treating DID, has been found to change the internal perceptions of the patient and/or ego-states.

Summary of the Literature

The intent of this discussion of the literature is to provide a bridge linking the early psychoanalytic theories of hysteria, or "dissociation" as it was later known, to the neo-contemporary theories of dissociation, including the neurobiology of dissociation and the etiology or the construction of alter personalities. John Bowlby's attachment theory provides the bridge between the shift in paradigms from an internal drive theory with a focus on wish fulfillment and fantasy, to a theory focusing on external environmental traumata. We discussed Mary Ainsworth's (1967) infant in a *Strange Situation* research and the identified patterns of attachment including secure, insecure avoidant, and insecure ambivalent. This was followed by Main and Solomon's (1990) later research and the identification of the disorganized/disoriented or "D" attachment pattern. It was noted that the D attachment pattern constructed between a frightening mother or secondary mother figure and a fearful infant might be a contributing factor to the infant's dissociation as a defensive coping style. The literature reviewed supports the theory proposed in this dissertation that there is a casual connection between childhood maltreatment and the development of dissociative disorders. It was noted that dissociative disorders, including Dissociative Identity Disorder and Dissociative Identity Disorder Not Otherwise Specified are no longer considered rare disorders.

Statistics were provided to emphasize that childhood maltreatment in North America is at epidemic proportions. We reviewed the strong and growing body of research that indicates that severe physical abuse and sexual abuse in early childhood is linked to the development of multiple personalities, also referred to by various authors as alters, ego-states, and Almost Normal Parts or Emotional Parts. Kluft (1993b) suggests

the various alters "live in different subjective realities. . . . [which he refers to as] 'multiple reality disorder'" (p. 147).

Research was provided to support the hypothesis that there is failure by the collective mental health profession to recognize, diagnose, and provide appropriate treatment for dissociative disorders — whether it be early in a child's life, or when the patient presents as an adult seeking treatment. This is most unfortunate because research also reveals that adults who have been misdiagnosed often spend on an average eight or more years, some as many as thirty-years, in treatment suffering with symptoms of DID or DDNOS before being correctly diagnosed.

We reviewed the availability of reliable and validated screening and diagnostic interview tools, such as the SCID-D-R, Revised Structured Clinical Interview (Steinberg, 1994a, 1994b, 1995), a tool that can be used by social workers, and the Dissociative Disorder Interview Schedule (DDIS) (Ross, 1997).

Finally, step or phase oriented treatment modalities that can alleviate suffering and even provide a cure were discussed. These modalities included the Trauma Treatment model (Ross, 2000), the Structural Dissociation Treatment model, (van der Hart et al., 2006), Sensorimotor Psychotherapy (Ogden et al., 2006), Eye Movement Desensitization and Reprocessing with adaptations (Twombly, 2000), adjunctive techniques such as hypnosis, and guided imagery with hypnosis (Lemke, 2007).

CHAPTER SIX: CLINICAL CASE MATERIAL

In this chapter, I apply the theories and models discussed above to clinical case material from patients I have treated in my private practice over the course of many years. All information was obtained during regular psychotherapy sessions and not as part of a research project. First, I present a profile of three patients with dissociative identity disorder (DID) to illustrate the lack of a secure attachment behavior in the mother/child dyad during the first year of life and the horrific and enduring childhood abuse that is believed to have contributed to the use of dissociation as a defense mechanism, and ultimately to the construction of multiple alternative personalities. Second, I will discuss the use of Steinberg's (1994b) SCID-D-R diagnostic interview tool with two of the three patients. And finally, I will include illustrative excerpts from several sessions with one patient.

Initially, all three patients discussed were doubtful of having the diagnosis of Dissociative Identity Disorder (DID), or Dissociative Disorder Not Otherwise Specified (DDNOS), and only two of them were willing to participate in answering the SCID-D-R interview questions. Two of the three profiles illustrate the somatic dissociation discussed in the above Sensorimotor Psychotherapy treatment model (Ogden et al., 2006). Furthermore, the profiles illustrate the challenges the patients experience in their daily life activities, including forming trusting and intimate relationships, completing school, employment problems, and other activities of daily living. Following the patient's profiles, I will discuss the initial difficulties encountered by the patients when attempting to complete the SCID-D-R diagnostic interview questions, the helpful information

gleaned from the tool, the mistakes I made, and what I learned from the process. Finally, I provide excerpts from various individual therapy sessions with one patient.

The Patient Profiles

Three patients with signed authorizations (see Appendix A and Appendix B) were selected from a group of many possible candidates for this work. The patients' names and specific information that is not relevant to support the *continuum construction theory* of multiple personalities has been changed to protect confidentiality. Additionally, for reasons of confidentiality, demographic information has been combined. However, the changes in the case material do not affect the diagnosis given or the treatment provided.

The three patients discussed include one male and two females who range in age from 45 to 70 years. The male patient identifies as being gay with no history of being in a heterosexual relationship. Both female patients are divorced, and both have adult children and grandchildren. One female patient claims to have had a past history of a relationship with a same sex partner.

The length of time the patients were in treatment with this writer range from two years to fifteen years; two patients had returned after taking a leave from one to seven years. The overall length of time since the patient's first contact with a mental health professional that provided a diagnosis other than DID or DDNOS, until completing the SCID-D-R, according to the information provided by the patients, range from two years to 30 years. However, information provided by three previous therapists differs. According to the therapists, two patients had been diagnosed with DID or Multiple Personality Disorder (MPD) many years previously, while the third patient was diagnosed with a Bipolar Disorder. This information contributes to the theory that many

patients spend years of suffering before being correctly diagnosed and receiving appropriate treatment.

Upon completion of the SCID-D-R (Steinberg, 1994b, 1995) diagnostic interview, both patients eventually accepted the diagnosis of DID — albeit with great hesitancy — and all three eventually left therapy somewhat improved, but without integrating personalities. The integration of personalities is very difficult work for the patient and while being accepting of the diagnosis is a beginning step, age may have been a deciding factor against these patients wanting to complete all stages of treatment.

The Case of M.

M. was born to parents who both worked. Therefore, M. was often left for several days at a time in the care of grandparents where she was sexually abused by a series of grandfathers. The grandmother, who was very much the mother figure, apparently knew of the abuse and betrayed her by failing to protect her (Freyd, 1994). In addition to sexual abuse, M. claims she was forced to participate in satanic animal rituals with blood sacrifice. If she displeased the perpetrator, punishment could mean being locked in a cage with a vicious dog or other threats of bodily harm, and being locked in a dark place without windows. Because she was often left with her grandparents for extended periods of time with no way of contacting her parents, and no effort on her parents part to contact her, M. felt unloved and abandoned beginning at birth and throughout her early years.

During elementary school years, M. describes an inability to concentrate or pay attention in class. Instead, she describes spacing out. When called upon by the teacher and unable to answer a question, she felt ashamed. Eventually, she developed hysterical deafness; literally she could not hear the teacher. At other times she describes being mute.

She was labeled retarded and put in special education classes. The shame of being sexually abused, labeled as retarded, and humiliated at school with taunting for having learning disabilities, all contributed to the formation of dissociative symptoms, including somatic dissociation, and the ongoing construction of alter personalities as a defense mechanism.

Dissociation allowed M. to separate from the physical and emotional pain experienced in her body. She could escape from the environmental traumata and go enter an intrapsychic world of fantasy where no one could find her and she could feel safe. The creation of multiple selves allowed M. to cope with the early and enduring years of emotional, physical, and sexual abuse. One of M.'s alter parts is the holder of physical pain experienced in her lower back and pelvic area. Yet, there are other younger parts who were able to be physically active without experiencing the sensation of physical pain. When M. switches back into her Almost Normal Part to carry out her adult activities she claims to have no memory of the younger parts, however, the sensation of physical pain comes back with a vengeance.

During the periods of time when M. does not feel pain due to an alter personality taking executive control of her body, she is experiencing anesthesia or loss of all sensation, and amnesia or loss of all memory for the pain. With each shift to a different part, M. experiences modifications in her character traits. As demonstrated when she switches from a child part that can move and play without discomfort to an adult part in severe physical pain. Nijenhuis (1991) places these symptoms in the category of "somatoform dissociation," which manifests disrupted mental synthesis.

M. has also described episodic visual anesthesia or impaired perceptions. In this state some objects appear much larger in comparison to her size. For example, she once gave me a gift that was the tiniest little decorative item imaginable, no bigger than a cork. I explored with her the meaning of the gift to determine whether accepting it might be clinically harmful. At first is seemed that the smallness of the gift was her way her being a part of my office without seeming intrusive. However, I would soon learn that the size of the gift was in direct proportion to her perception of herself. She saw herself as tiny and insignificant.

There are times when M. has shared sketches of herself. In some drawings, her self-image is a ghostly shape, much like a wisp of angel hair on a Christmas tree. I would suggest that this image represents a fragment of her self and not a separate identity. In some sketches M. has no arms, or no feet, or no face. In other sketches her face is drawn without a mouth, but with dark eyes as big as saucers. In fact, several patients with DID have produced similar self-drawings with the mouth-less face representing the fear of speaking of secrets, the lack of feet as the inability to run away from the perpetrator, and the wide eyes depicting the horrors that they have witnessed. In all of M's sketches there is indeed a theme of fear, helplessness, and vulnerability; all typical for patients with DID.

When M. began therapy she was living alone and experiencing the empty nest syndrome. She felt that her life had little meaning and she had no hope for a better future. When the loneliness became overwhelming, she would frequently self-harm by cutting; often calling this writer with threats of suicide.

Eventually, after more than a decade of psychodynamic therapy, M. became involved in a committed relationship that once again gave her life meaning. She also became more assertive in setting limits and boundaries and in communicating her needs to both her immediate family as well as to her extended family members.

Although M. demonstrates many positive changes in her life, every new day brings new challenges, which can trigger dissociation at an inappropriate time. Staying present in one adult persona or "Almost Normal Part" can be exhausting. DID patients consume a great deal of energy when switching parts or when attempting not to switch (van der Hart et al., 2006). For M., the goal of integration was abandoned long ago. She feared that the memory work would cause massive internal affect-dysregulation that she would not be able to handle. While dissociating remained a problem for M., especially under extreme stress, it became more manageable with treatment. When stressful events were approaching she learned to map out a plan of action to avoid some known triggers, which often included relatives, allowing her to stay within her window of tolerance (Ogden et al., 2006). In her last session, when I inquired about the frequency of switching parts when under stress, M. responded that perhaps she no longer needed all of the parts.

The Case of C.

I treated C. early in my career as a therapist, at a time when I knew very little about dissociative disorders. After a few years in therapy for symptoms of depression, C. terminated treatment. Many years later, following a serious suicide attempt, she called to resume therapy. Upon reviewing old medical records, I noticed similarities between the symptoms that C. had initially reported and those that meet the criteria for a dissociative disorder. Additionally, her psychosocial history suggested that she was a good candidate

for a complex trauma diagnosis or, at the very least, her history suggested a rule-out of Post Traumatic Stress Syndrome. In sessions, I began to further explore her childhood history and re-evaluate her symptoms, especially that of amnesia, a required symptom for the diagnosis of DID. For example, she seemed to have no memory of what we talked about from one session to the next, and, like many patients with DID, she kept obsessive records of her activities.

For C. the memory of her trauma history dates back to her early childhood years, perhaps to age four or five; she is never sure about the time frame of her life history. During her early formative years, C.'s father traveled and was away for extended periods of time and her mother worked. The hired baby-sitter is described as a woman who sent the children outside to play unsupervised; thus, even at the tender age of four or five years, C. found herself taking responsibility for the welfare of her younger siblings.

C. further reports that her mother was neglectful. For example, she would become preoccupied and forget to pick her children up on time from elementary school; often arriving after dark. At other times, C. describes how her mother would drink wine when arriving home from work and then fall asleep on the couch before dinner. C. was left to her own creativity to fix dinner for her younger siblings, usually sandwiches. Furthermore, C. had learned early in life not to complain because her mother could also be emotionally and physically abusive. C. knew that it was safer to stay out of sight and to be silent. Being silent or mute is a common character trait of child alters who fear speaking.

C. also reports being sexually abused at approximately age five years by an older neighborhood boy. She claims that she never reported this to her mother for fear that she

would be blamed and severely punished. Although C. denies being sexually abused by any family members or other adults, she does recall an incident where a pelvic exam was performed for medical reasons. While she does not consider the exam to have been sexual abuse, believing she had a medical problem — unrelated to the incident with the neighborhood boy — she does recall feeling shamed by the experience. However, sexual abuse by a family member was never ruled out.

By the time C. was an adolescent, both parents had became heavy drinkers who fought bitterly in front of their children. C. recalls one frightening incident when she was perhaps four years old and heard her parents verbally fighting behind closed doors. When C. heard her father yelling she literally believed her father was being killed. C., who wanted to believe that she was daddy's special girl, was devastated when her father announced, perhaps under the influence of alcohol, that he wished that she had been a boy. C. does have a male alter personality. While it never became clear when the male alter was constructed, it was clear that the alter took on the role of attempting to gain father's favor.

C. describes her teenage years as a life filled with domestic violence, corporal punishment of the children, verbal abuse, and the constant fear that someone in the immediate family would be murdered. While the specific details of most of C.'s teenage years are a blur, she does recall many incidents of self-harm by burning and cutting.

Over the course of many therapy sessions, I would learn that C. had an intense phobia of her own body. The thought of exploring what her body was feeling at any given moment caused her to become psychically disorganized. During one discussion of how she could get in touch with what her body was feeling during stressful events at

home she became terrified. Yet, literally with the blink of her eyes she immediately devised a plan stating in a monotone voice that she could do this if she noted her bodily feelings as if she were doing a crisis body assessment on someone else. C. had switched personalities and an alter, previously unknown to me, had taken executive control of the body. Over time many more alters with specific roles would be identified, some who would be considered Almost Normal Parts and others known as Emotional Parts (van der Hart et al., 2006).

The Case of S.

S., whose treatment will also be discussed below, identifies himself as a gay male with a college degree who has never been in a committed relationship. S. recalls only a few sketchy memories of his childhood before his high school years; however he has learned about some events from a reliable relative.

S. reports that both of his parents were severe alcoholics. His mother drank while she was pregnant and continued to drink heavily throughout his childhood. His father worked during the day and spent most evenings drinking with his buddies. S. recalls many episodes of verbal fighting in the home. In contrast, he describes himself as a quiet child who would never raise his voice to his parents. According to a relative, a male babysitter sexually abused S., a memory he cannot recall. As a teenager, S. has a flash-bulb memory of being in a compromised situation with his father, one that might suggest it was sexual in nature, but S. has no access to the full memory and does not know what transpired. Consequently, S. has spent a lifetime asking questions about this situation, but they remain unanswered.

As an adult, S. has suffered from severe depression with suicidal ideations, amnesia, and an eating disorder. He has coped with his traumatic childhood, including the emotional unavailability of his mother and later horrific abuse, by dissociating and creating alter personalities that contribute to keeping his activities compartmentalized. Different alters handle different roles. He has one part who will socialize, but this creates conflict with the parts that fear being with adults. He claims that in some social situations people have asked him to speak up because they are unable to hear him. While S. believes that he has a soft voice, this is not the case in therapy sessions. In general, it is not unusual for a patient with DID to have a child alter (there could be several child alters) that speaks in a low tone of voice, sometimes even mumbling. Recall that S. grew up being taught that children were to be seen and not heard; and a violation of a rule could result in extreme punishment. Furthermore, S. is easily intimidated by anyone, male or female, who speaks with a commanding tone of voice. He is not comfortable talking on the phone; believing that his voice sounds like that of a child. Like other patients with DID, S. is much more comfortable communicating by e-mail. In fact, the use of any technology, which provides a protective barrier, allows S. to experience the much longed for feeling of being in control.

Over the course of a few years of treatment, S. went from being terminated from multiple jobs to holding down steady employment. That is not to say that he did not continue to have daily problems: making many mistakes at work, being late for work, losing time, and interpersonal relationship problems. But, perhaps the most problematic of his symptoms was that of switching parts, especially on the job when he would switch

to a younger part that could not remember the required skills to perform tasks, which contributed to a constant fear of termination.

In the next section, the use of the SCID-D-R diagnostic interview tool will be discussed.

SCID-D-R Diagnostic Interview Tool

Two patients participated in completing the *Structured Clinical Interview for DSM-IV Dissociative Disorders Revised*, (SCID-D-R) authored by Marlene Steinberg (1994b), which is considered to be the "gold standard" (Steinberg & Schnall, 2000, p. xvi) for assessing dissociative disorders. Steinberg instructs the therapist to ask the interview questions in one of the first sessions and then write the patient's answers and comments in her workbook. However, due to the length of time the patients had been in treatment with me, which was between two and fifteen years, and due to the vast amount of personal information that I had already accumulated, I chose to try a slightly different approach. I now believe that choice was an error.

I worked collaboratively with the patients in session to complete the first chapter of the SCID-D Revised workbook covering demographic questions. I then contracted with each patient allowing them to take the workbook home with instructions to complete only one chapter per week. The agreed-upon plan was to review the answers to each chapter in the following session. Admittedly, I held the thought in the back of my mind that if the patient had a diagnosis of DID, an unknown alter might answer the questions. Then, I would not know for sure which alter had completed the chapters, but that could also be true if we completed the chapters in session.

The SCID-D-R workbook is organized so that each chapter, most only a few pages in length, covers one of the five core symptoms of dissociation, including amnesia, depersonalization, derealization, identity confusion, and identity alteration, with follow-up sections when further clarification is needed. Each patient was given strict instructions that if at anytime the questions caused him or her to feel distress or even slight discomfort, they were to write STOP at that precise question and close the book. They could contact me by phone if they needed to talk between sessions. If the patient completed the entire chapter, the instructions were to stop and not proceed to the next chapter. In fact, I wrote STOP for the patient at the end of the assigned chapter. It is interesting to note how differently each patient approached the task.

I have purposefully chosen to consolidate the information regarding how the patients completed this exercise and their genders for reasons of confidentiality as well as for space. One patient could not tolerate working on the material alone at home and reported feelings of fear and distress. Due to the distressful feelings experienced, we contracted to only work on the material together in session. I would learn much latter that when this patient was a child, an alter had written down something very disturbing. Later, when the patient read it back it sounded so much like a different person, so much so that the experience was frightening. The writing was immediately torn up and a vow was made never to write anything down again.

Another patient could not follow directions. For example, when answering the yes or no questions, a large circle was drawn around both choices. Instead of completing only one chapter during the week, the patient completed additional chapters leaving some answers blank. This is significant because patients with DID who switch to a child alter

are unable to follow directions as given to an adult. Homework for the following week was to complete only one more chapter. Upon return the following week, the patient had completed all five-core chapters and requested that I go over them before we meet again. I honored the patient's request, but later, upon reflection, found myself resenting the expectation that I was to use my own time to go over the work when we had contracted to do this in session. I suspect that a different alter had raced through the workbook at home and that the presenting alter was not interested in the assignment. Breaking contracts in all areas of life, including at work, in relationships, and with me, would become grist for the mill in future sessions

Clinical Case Material: Excerpts From One Patient's Treatment Sessions

The following excerpts are taken from several different treatment sessions with S., a gay male whose primary goal in life is to be in an exclusive and committed relationship, something he has never experienced. He was initially referred to me when he was experiencing an episode of severe depression with suicidal ideations. Prior to the referral, multiple clinicians had treated S. from different disciplines utilizing a variety of treatment modalities, including psychoanalytic therapy, group therapy, hypnosis, and many different pharmaceuticals. S. claims that nothing had resolved his problems. He still did not have a life-partner, and could not hold down a steady job. The referring clinician verbally reported that a diagnosis of DID would account for much impairment; however, the patient was in denial of the diagnosis.

Therapy sessions with S. have been like an unequal taffy pull; he pulls and pulls, and I hang on. He often arrives five to ten minutes late with a full agenda that may take-up the entire session. Invariably, his agenda centers on an interpersonal relationship

problem: a feeling of being rejected or slighted by friends or by someone he met over the Internet. Because he needs the security of having a social activity marked on his calendar so that he will not be at home alone, he pushes for a commitment from friends or from potential dates. When a commitment is not made, he tries to hide his anger believing that he must have *done something* to offend his friends, otherwise why would they be avoiding him. Invitations to take his friends to dinner and or to a movie so that they will like him are not reciprocated. Thus, he feels that he has no control over how his friends treat him. Therefore, having a predetermined agenda with nonstop reporting when he comes to sessions provides S. with a feeling of being in control. Most interventions by this clinician are not welcomed and are considered unimportant. He also does not like to review anything previously discussed. If he even thinks that I am going to ask a question that he does not want to deal with he will respond, in an indignant tone, that we have already discussed the issue and that he knows what I am going to say. In those instances, not only has S. been incorrect in his predictions, but also, metaphorically, he has amputated both of my legs. If I say anything in a manner in which I think I am showing concern, S. hears me cautioning the alter that repeatedly gets into trouble with reenactments. He becomes angry and I am labeled the bad parent. When exploring his anger and his need to silence me, S. will say that he believes that his parents lectured him. Because he has amnesia for most of his childhood, he claims that it just feels like accurate information. I suspect an insecure child part is reacting with a negative transference.

In sessions, S. cycles through dissociated parts of various ages. Frequently he exhibits behavior that is reminiscent of a young child. For example, he will vigorously

rub, almost digging, at his eye with the back of his hand, as a sleepy toddler might do. At other times, he will pull on his ear, like a self-soothing toddler. However, when S. is observed fully switching to a child part, his head will lower and cock to one side, his facial muscles will soften, his mouth will form a coy and mischievous grin, and his feet will turn inward. In contrast, when S. is angry with me his facial muscles will twist and contort into an animated angry expression; perhaps that of an older child. And sometimes, when S. intently zeros in on something that I have said, his awareness begins to constrict, he lowers his head, leans forward, squints, and stares at me with piercing eyes, like a race horse wearing blinders and ready for the run. I know that he is looking at me, but I sense that he is not present with me. It appears that he is straining to hear what I am saying, and I do not have a soft voice. If he is very angry with me he will drop his head to the side and stay silent.

In an attempt to help S. get in touch with what his body is trying to communicate, (Ogden et al., 2006), I might break the silence and say to him, "I think you are angry with me." The fact that I recognized and validated his feelings brings him back into the room to be present with me. Later, at an appropriate time, I might point out to him how defensive I felt when his body posture became rigid and his facial expression became angry. S. seems to always react positively to my honest feedback.

In other sessions, I might comment on his movements or changes in his facial expression by asking," What just happened then?" S. would get frustrated at not being able to feel the bodily changes and not understanding what I had observed. He believed that if he was not aware of the facial expressions, he could not change them. This was in keeping with his belief that something about him was broken and needed to be fixed.

In the following session, after bringing these bodily changes to his attention, he would share how his friends had also begun to make comments about his facial expressions, with one friend calling to his attention that he always looked angry. When his angry facial expression was brought to his attention at work, he was extremely embarrassed and feared losing his job. Since many clients with DID have an unrealistic self-image of themselves it often helps to video tape sessions. For example, some patients with DID try to never look in the mirror. If they are expecting to see a child's face and body, and instead, an adult face looks back or visa versa, it can be a terrifying experience. S., eager to see himself on the screen, agreed to be video taped. However, here a word of caution is in order. Patients who may have been subjected to being photographed or video recorded for the purpose of pornography (Ormrod & Finkelhor, 2005, p. 1-3) might not be able to tolerate being video taped in sessions. This is a slippery slope that must be handled with extreme sensitivity and thoughtfulness or perhaps not utilized with some clients.

My usual procedure for showing a patient with DID a video taped session is to allow the patient to be in total control of the remote control. This way the patient can pace the amount of information that they are receiving, visual or auditory. The patient can fast forward or rewind, turn the volume up or down, or turn the recording off at-will. As S. watched the recording, I watched S., keenly observant of his body language and facial expressions.

S. pushed the start button and focused intensely on the screen. About two minutes into watching the video recording, S. suddenly sat upright on the edge of the chair, leaning forward for a closer observation. His facial expression turned very serious and he

held his hand over the side of his face, as if aghast. He made comments about how old he looked, how his voice sounded, and how he talked too fast. In short order, he announced that he had seen enough and could not take anymore. I replied softly, "You are in total control of the remote. If you don't want to see more, you don't have to. You can stop the video at-will. You have the controls." I got up to adjust the lighting in the room, but he decided that he wanted to watch more.

I have found that this simple interaction of being in charge of the remote control while watching your own image is a very powerful intervention for patients with DID. S. was able to see the reality of being an older adult. He commented that he did not like the way he looked or sounded. He repeated how he did not like the wrinkles in his face. S. spoke in a very sad and low voice about how the image that he had of himself of a much younger adult who could attract younger men was not what he was seeing on the recording. He recognized that perhaps his self-image, that of a younger alter personality, was contributing to his inability to find a significant other that was interested in him.

In addition to being unhappy with how old he looked, and how his voice sounded, S. seemed the most surprised, and concerned, with his gay mannerisms. He reported that he had spent a lifetime trying not to look gay. We processed how hurtful it was during his adolescent years to be bullied by other boys for looking too feminine. It is significant in understanding the *continuum construction theory* to mention that S. did not have supportive parents that he could go to when he had been bullied. In fact, S. risked severe punishment if he were to tell his parents. This information about his childhood was noteworthy because the Almost Normal Part of S. claims that he has amnesia for most of his childhood. Aside from being bullied, he offered no additional childhood

memories. I did not push for more details knowing the pain that he had just re-experienced. I was grateful for the opportunity to learn more about S's childhood and that S. had an opportunity to connect with another part of his identity.

Of all the challenges that I have encountered working with S., probably the most difficult aspect of our relationship was working with the suicidal part. I came to understand how his suicidal part that carries all the feelings of hopelessness and despair also allows S. to feel that he is in control of his life. When the disappointment of a relationship becomes unbearable to discuss, he becomes very narrowly focused and lets me know that he is running out of reasons to live. When I become concerned about his potential to carry out a suicide plan, and therefore, I want to discuss it more, he becomes guarded and angry. In one session, he reported that he would no longer bring the topic of suicide up. Upon further exploration, S. shared that a previous clinician had warned him that if he talked about suicide again in therapy he would be terminated. We discussed his fear that I, too, might abandon him if he talked about suicide. I suspect that the suicidal part of S. had just spoken and needed validation. Furthermore, it is my clinical opinion that his *internal family system* feared that I would abandon all the parts if the suicidal part risked sharing again in session.

As an ethical clinician, I always take suicidal comments seriously. I must use clinical judgment in determining what necessary steps must be taken to keep my patient safe. Since there is a statistical probability that S. may, at some point in his life, make a suicide attempt, it is not always easy for me to trust his judgment. However, without overreacting, and without compromising what little trust S. had with me, I informed S. that we were in this together and that I would not abandon him for talking about suicide.

In fact, I told him that he could have all the suicide *plans* that he felt he needed. I understood that having a suicide plan made him feel he was in control of his life and provided him with a feeling of comfort. Indeed, it is a paradox that having control over your life means having control over ending your life. On the one hand, believing that he is in control can help him to endure longer. On the other hand, I reassured him that if his plan should escalate to the level of *intent,* I would take whatever steps were necessary to keep him safe. He accepted my reassurance and many months would pass before he broached the topic of suicide again. Admittedly, I often felt the fear and the helplessness that S. must have felt and it was difficult not to overreact.

In another session, S. shared that he has been making many mistakes at work, especially after being interrupted by someone. We processed his history of getting easily distracted, his difficulty multitasking, and how he sometimes loses mental access to the skills needed to do his job. At times he may sit and stare out the window until it is time to go home, and then take work home for completion where the environment is less stressful. Experiencing memory impairment causes him to feel powerless and even stupid. If others at work notice his inability to complete a task or to complete it without error, he experiences humiliation, which then leads to dissociation: either shutting down or switching to another alter. Subsequent experience has informed me that there is always an alter, perhaps one containing introjects from a perpetrator, that wants to fire me.

A few years and many sessions into our therapeutic relationship, we dealt with S. wanting to fire me; claiming that I make him angry asking him questions that are not relevant to *his* agenda for the session. At first, I found myself trying to accommodate his complaints and evaluate myself after each session. In some sessions, I found myself

asking permission to say anything least I make him angry. After weeks of feeling helpless myself, I began to look for a pattern to try to better understand when he accepted my questions and when my questions especially irritated him. I came to suspect that I was asking for information from an alter that did have access to that specific memory. I also came to understand that alter personalities were competing for my attention. Then, upon returning after a session when he had felt especially irritated, he announced that he thought he should find another clinician that he could work with. I handled this by validating his frustrations and reassuring him that I wanted only what was best for him. I suggested that he bring me the names of providers that he was considering and I would give him my opinion about their reputation and whether or not they might be experienced in treating DID.

While it might sound like I was being too compliant in helping S. find another clinician, my intention was give him a feeling of control over his life choices. Yet, at the same time, I strongly reassured him that I considered myself to be his therapist and until he made a decision to *leave me*, I would be holding his weekly day and time sacred and that I would be waiting for him. This was a new experience for S. I was not the alcoholic parent that was unavailable to him and I was not discounting him. He did not try to fire me again for many months; however, I knew there would be future opportunities. I also took comfort in knowing that it is through the misattunements and repairs that authentic relationships transpire and evolve.

Months later, S. again became suicidal, fearing that he was going to lose his job. I insisted that he make an appointment to see a psychiatrist, one that he could work with to have his medications reevaluated—he had fired his last psychiatrist. After discussing a

few different names of psychiatrists, both female and male, and both heterosexual and homosexual, a referral was made. I also recommended that he temporarily increase his therapy sessions to twice a week, which he reluctantly agreed to do. His hesitancy was that he might get invited out and need to cancel our session. I thought this most interesting since suicidal patients are generally not looking for a good time while they plan their death, however, DID patients are different. S. agreed to scheduling two sessions per week and I determined it was my ethical duty to seek consultation. After having S. sign an authorization allowing me to speak to a previous clinician, I made the call. S. was pleased that I cared enough about him to seek consultation. I am sure that it made him feel very special.

In the following session, I shared with S. some of the things that were discussed in my consultation. I told him that I had learned more about a child alter that had spent a lot of time in sessions with his previous therapist. I explained to S. that I thought that I had seen glimpses of the child alter through facial expressions, body language, tone of voice, etc., but I had not had the pleasure of talking to the alter so directly. I also commented that perhaps there were other parts that were competing for my time in our sessions. I believe that this was a turning point in our therapeutic relationship. In the following sessions, S. began to tell me secrets that he claimed he had never revealed to anyone.

During a following session, S. initiated the conversation talking about a man that he had met, but with a significant twist to the story. S. reported that he had been communicating with a man from another state whom he met over the Internet. After making plans for the man to come for a visit and stay in his home for several days, the

man was now backing out of the plan. S. reported that he was hurt and humiliated more than ever before. He described the man as belonging to a certain population that S. considered beneath him and still he had been rejected. He worried that he would be humiliated and ridiculed by his friends if they found out. This sounded once again like the familiar fear of being bullied; only this time it was not for being gay.

S. recognized that he continued chasing after men even after being rejected. He communicated an understanding that children who do not get the positive attention they need from their parents will find other ways to get attention, even if it is abusive. He also came to an understanding that as an adult he continually settled for abusive relationships, but had not recognized the abuse while it was happening. He questioned what was wrong with him? Before I could respond, S., in typical fashion, took control of the dialogue, trying to predict my response. Again, without waiting for my reply, S. reported that he had been thinking about the answer to this question himself. He then reflected back to his childhood, around the age of five or six, an age when children become easily absorbed in creative play and fantasy (Young, 1988a), when he played cops and robbers with friends. Even at this young age, S. always chose to play the bad guy who would end up dead. He continued without pause to share a poem about a little girl being physically abused by her father who would play dead when she could no longer take the abuse. Now that I was allowed to speak, I explored with S. if he thought the little girl in the poem was literally dead versus being the victim of a metaphorical "soul murder" (Shengold, 1989) by being abused by her father. Perhaps she was not literally dead, but only felt dead inside as described by patients who dissociate (Schore, 2009, p. 115).

This philosophical question segued into a review of the abuse that he had been subjected to as previously stated. I suggested that since this abuse happened to him at such a young age, perhaps other things happened to him that led him to play the victim role or to *play dead.* Many sessions later, S. revealed that his mother had been ill a great deal during his younger childhood years with several hospitalizations lasting for extended periods. It is possible that the separation from his mother and the fear that she might die was reenacted in his play. However, one could also surmise that during this timeframe he had been subjected to abuse mentioned above. It is just another piece of a very complex puzzle. Perhaps, in time, all the pieces will come together.

In summary, after becoming established with a psychiatrist with whom he was comfortable, S. eventually terminated therapy. And so, we said our good-byes.

Terminating therapy with S. was bittersweet. There is no doubt that he was one of the most challenging patients I have ever worked with. Like the unequal taffy pull, I sometimes dreaded the next session after he had been angry with me. Yet, there were parts of him that I truly enjoyed. This is to be expected when working with patients with multiple personalities. It is a challenge to be accepting of all parts; however, remembering that they are all part of the whole self and were constructed for the purpose of survival helped this author to keep negative feelings in perspective.

S. did not remain in therapy long enough to complete the three stages of treatment that lead to integration. However, he accomplished many other goals in stage one of treatment. The first goal, which is to establish a secure and trusting therapeutic relationship, *sometimes with one alter at a time*, was slowly evolving as evidenced by the secrets that were revealed by more trusting alters. I strongly believe that in addition to

providing safety, predictability, and consistency in the therapeutic frame that the reparation of many ruptures in the dyadic interplay contributed to developing a measure of trust in the therapeutic relationship.

Other goals accomplished in therapy included developing basic resources. For example, after being terminated from employment multiple times, S. had obtained a good enough job that provided employment as well as financial security. With therapy, S. was able to identify that each termination could be traced back to interpersonal relationship problems that triggered a switch to a child alter. In some instances, the child alter did not have access to the technical skills needed to do the job. However, in all instances, the child alter did not have the social skills required to handle the interpersonal relationship conflicts. This knowledge allowed S. to be better able to manage work and personal relationships. He was able to identify the triggers and thus, be proactive to prevent some of the frequent episodes of switching. He was also setting boundaries with people at work who had previously taken advantage of his vulnerability.

S. had also made progress with interpersonal communications skills outside of work and was becoming more comfortable and confident when socializing. However, with all of the many positive changes that were achieved during stage one of treatment, his life still remained in a constant state of chaos. Even though he had acquired steady employment, the fear of being laid off was always looming in the background. He continued to feel slighted when friends spoke of events that he had not been invited to attend. He complained that his phone never rang, yet he avoided directly communicating over the phone preferring the safety of distance that sending emails provided. Perhaps the

most significant change that marked developmental growth was his ability to be comfortable being at home alone without a social event marked on his calendar.

In treatment, S. never fully reached stage two, the memory work. Indeed, S. had revealed a few secrets, but revealing secrets does not necessarily mean remembering specific memories of the childhood abuse that led to the construction of alter personalities. I believe that in the initial part of stage two of treatment, alter parts who have been developing a trusting relationship with the clinician will intentionally begin to reveal secret information about themselves and about current event secrets that are not shared with other alters. For example, the part who revealed the secret of attraction to a certain population of men — a secret he was embarrassed to tell his friends — was demonstrating trust in the therapeutic relationship and revealing a current event secret.

On a different occasion, S. switched to a part who spoke in a child's voice if only for a few moments. Yet, no secrets of suspected sexual abuse was revealed. During another session, S's facial expression became contorted and his voice deepened so that his presentation was that of an old man. Could it have been a perpetrator? It's possible. In time, additional therapy may have revealed the alter's identity. For now, the painful memories of abuse experienced in early childhood that had led to the development of alter personalities would remain locked away indefinitely. Indeed, stage two of treatment, memory work, is painful and hard at any age, but perhaps more so for an older adult. I suspect that S., who is approaching his "golden years" will avoid the painful recall of abuse and continue his life living in an unintegrated state, forever seeking his missing object or his life partner.

CHAPTER SEVEN: DISCUSSION

This theoretical dissertation provides an exploration into the intrapsychic world of individuals who created multiple selves or multiple identities, manifested in alter personalities that are amnesic for each other as an adaptive mechanism to cope with memories of horrific childhood abuse. Kluft's four-factor theory, as well as elements from other prevailing theories regarding the etiology of the construction of multiple alternative personalities, have been integrated. This integration has provided the basis for the construction of a new theory, *the continuum construction theory.* It is hoped that this developmental trajectory or road map will alert clinicians and other professionals to the symptomatology in the first year of life, especially with high-risk mother/infant dyads. Further, it is also hoped that the *continuum construction theory* will enable professionals to recognize and closely monitor the symptomatology well before it appears in early adulthood. Further, it is hoped that this new theory will assist clinicians when screening, assessing, diagnosing, and providing effective treatment to persons who have been diagnosed with dissociative identity disorder (DID) or dissociative identity disorder not otherwise specified (DDNOS).

Drawing from early psychoanalytic theories, Bowlby's attachment theory provides a transition from Freud's internal drive theory to a focus on external traumata that was to be found in the early maternal infant/mother figure dyad. Research by Solomon and George (1996, 1999), Main and Hesse (1990) and Liotti (1992, 1995, 1999a, 1999b, 2009) identified a disorganized/disorienting attachment pattern that could be caused by a frightening mother, thus linking attachment theory to contemporary trauma theories. Perhaps most significant, the six-stage linear theory of *continuum*

construction identifies a plausible evolutionary process as it relates to the causation and construction of multiple personalities in DID and DDNOS.

This study also identified several courses of treatment utilizing various modalities that have the potential to relieve or cure the suffering of individuals who utilize alter personalities as a habitual coping strategy throughout their lifespan. In addition to the traditional psychoanalytic psychodynamic treatment modalities, the more contemporary models, i.e., the body-oriented model of sensorimotor psychotherapy, eye movement desensitization and reprocessing (EMDR), guided imagery, and hypnosis with guided imagery all offer alternative methods of treatment. While all the above treatment modalities have shown positive results for integrating the dissociative elements of the personality system, it is the underpinnings of the therapeutic relationship that builds trust and provides a safe therapeutic frame that promotes change and effects cure.

The membership of the International Society for the Study of Trauma and Dissociation (ISSTD, 2010) is comprised of the leading authorities in this field. And as such, the organization has evolved a standard of guidelines for treatment. Therefore it might be expected that any new theory regarding the development of alter personalities in persons diagnosed with DID or DDNOS be held to these standards and be compared to the prestigious Richard Kluft's four-factor theory. A survey of the literature as discussed by Wieland (2011, pp. 6-7) reveals that most prevailing theories of the causation and construction of DID include some, if not all, of the elements of Kluft's 1984 model as discussed by Wieland (2011, pp. 6-7). Other prevailing theories contain some, but not, all of the elements proposed in the new six-stage theory as previously defined. I offer a

comparison of the *continuum construction theory* against Kluft's four-factor theory, both defined as a developmental course for the construction of alter personalities.

The first factor in Kluft's (1984, 1988b) four-factor model posits that the individual must have a *biological capacity to dissociate,* which has been found to cluster in families (Yeager & Lewis, 1996). The second factor, *activation of the defense mechanism of dissociation,* is demonstrated in a 1991 study by Sanders and Giolas that found a correlation between dissociation and adolescents who have experienced sexual abuse and a negative home atmosphere (Wieland, 2011, p. 7). The third factor, "'*the linking of the dissociative experience to a part of the self-system'* [emphasis added] draws attention to the relationship between early onset of trauma and dissociative identities" (p. 7). Kluft's fourth factor holds "that a lack of *'nurturing and healing experiences'* [emphasis added] during the early years determines whether dissociation develops to the point of separating individual functions" (Wieland, p. 7). Wieland interprets this to mean that the mother figure must "stay attuned to whatever distress . . . arose in the infant or child and allow that distress . . . to be experienced within a safe setting and then provide soothing" (p. 7).

The comparison of the six-stage *continuum construction theory* and Kluft's four-factor theory reveals that Kluft's theory is lacking two significant factors; the role of the disorganized attachment pattern, and the role of fantasy in the creation of imaginary characters. This is not say that Kluft has not conceptualized and discussed these factors elsewhere. In fact, Kluft's case studies have mentioned both the use of imagination and introjects, however, they were omitted from his four-factor theory. For example, as discussed earlier, Kluft discusses a young boy, "Marvin," who created an alter identity,

Captain Kirk, based on a character from the television series *Star Trek* (Roddenberry, 1966-1969). Kluft then identifies Marvin's father as Captain Kirk, the introject who had been incorporated into the imaginary character to form an alter personality. Furthermore, Kluft does not clarify the process or time line of the imaginary character blending with the introject, Marvin's father, to form the alter identity. We also do not understand if this blend of the imaginary character with the introject was conceptualized as an evolutionary process, a process that could be better clarified using the six-stage linear *continuum construction theory* that identifies the creation of imaginary characters prior to the blending of internalized introjects, which is then followed by the construction of an alter personality.

Furthermore, Kluft's theory, while addressing a lack of *"nurturing and healing experiences"* as the fourth factor, fails to address the contribution of attachment patterns in the development of alters; specifically a disorganized/disoriented attachment pattern. However, this omission is understandable since Kluft's theory, published in 1984, preceded the research of Solomon and George (1999), Main and Hesse (1990), and Liotti (1995, 1999a, 2009) on disorganized/disoriented attachment patterns.

In his defense, Kluft (2011) addressed the omission of attachment theory in the newly published Foreword of Wieland's seminal work *Dissociation in Traumatized Children and Adolescents*. With regards to his early publications in 1984 and 1985a, Kluft wrote, "In my eagerness to demonstrate the existence of childhood DID, I did not think to describe cases in which only precursors, formes, frustes, or marginally diagnosable phenomena were present" (p. xiii). He further contends that in his earlier cases, attachment was only a compelling concern in one case. However, in regards to

Wieland's text, Kluft notes "attachment was a central ubiquitous organizing paradigm. In earlier cases the identification and treatment of trauma played a more central role and was the predominant area of concern" (p. xi).

In comparison, the new six-stage *continuum construction theory* identifies a disorganized/disoriented attachment pattern in which the infant develops multiple segregated models of self and mother figure as a required antecedent in the evolutionary process of the construction of alter personalities. Furthermore, the six-stage model identifies the utilization of imaginary playmates or characters preceding their blending with introjects as points on the linear continuum in the creation of alter personalities.

The six-stage theory, while adding to the number of factors that contribute to the construction of alter personalities, has perhaps omitted important factors from Kluft's conceptualization. For example, the *continuum construction theory* assumes that every individual has the *biological capacity to dissociate* when dissociation is measured on a range from non-pathological dissociation to extreme dissociation (Wieland, 2011, pp. 6-7). Furthermore, infant research studies demonstrate that a baby who has been overly stimulated by the mother figure will turn away with downcast eyes and disconnect, or in Janet's term "*disaggregate*" from external stimuli. This baby has demonstrated a biological capacity to dissociate and self-regulate.

Kluft's third factor, *the linking of the dissociative defense with a part of the self-system* is not stated as such in the *continuum construction theory*. However, it may be substantially addressed with a similar meaning under stage three, "selective exclusion" of information – dissociation, and under stage five, the use of introjects in the construction of alter personalities.

From this comparison, it is concluded that the six-stage model provides a new theory by expanding and enriching Kluft's four-factor theory and by bringing together elements from other theories, e.g., Young's (1988a) theory regarding creativity employed in the defensive process of constructing an alter personality under one rubric. This new theory also offers clarity in the understanding of the causation and construction of multiple alternative personalities in persons with dissociative identity disorder or dissociative identity disorder not otherwise specified.

Limitations

The data for this study was derived from several sources, each with inherent limitations. These sources include (a) a data from the literature, which is prone to several forms of distortion, revision, and reworking, (b) a review of medical records with information that suggests that some patients were misdiagnosed, (c) the patient's self-report when they may be amnesic for other alters and for their own history, and (d) this author's observations, which at times could be subject to misinterpretation.

Additionally, without documentation from child protective services, court proceedings, the media, from reliable family or friends, or from other reliable sources, it is difficult to validate the information from retrospective account into scientific fact. Additionally, retrospective accounts of attachment patterns are speculative at best without empirical research to substantiate the attachment measures.

Suggestions for Future Research

Future research will be required to validate the *linear continuum construction theory.* A suggested method of study might require longitudinal empirical studies. The sampling population should be selected from populations identified as high-risk women,

preferably while pregnant, to allow for the recording of trauma to the fetus in utero. For example, trauma to the fetus in utero could be the result of the pregnant woman being a victim of domestic violence, using drugs or alcohol, and even invasive medical procedures to the mother or to the fetus. Anther high-risk population is pregnant women who have unresolved trauma in their personal histories. This group could include women who were horrifically abused in childhood; women who know that they were raised by a mother figure who may have been diagnosed with DID or DDNOS; or a mother figure with a severe mental illness, such as schizophrenia. These same groups could also be target populations to study after giving birth. Other interesting populations to study might include infant/mother figure dyads with adoptees, and infants born to mothers who had lost a child within two years preceding their own birth.

Conclusion

As stated in the introductory chapter, there is no one way to understand the etiology or the complexities of dissociative identity disorder (DID) or of dissociative identity disorder not otherwise specified (DDNOS), the most challenging of mental disorders.

Providing clinical treatment to patients diagnosed with DID and DDNOS has presented many challenges for me as a clinician. These challenges included understanding the etiology of the disorders, and more specifically, understanding how an alter personality is constructed; learning new diagnostic skills (i.e. the SCID-D); recognizing when a patient is dissociating and shutting down; identifying alter personalities with their idiosyncratic characteristics; understanding each alter's defensive purpose in the intrapsychic system; recognizing when the patient is switching

personalities or ego states; and choosing or designing effective treatment methods that will not re-traumatize the patient.

This is a lot to learn. Working with patients who present with multiple alter personalities or multiple realities is challenging work. Knowingly talking directly to alter personalities who have achieved separate identity status, but who are amnesic for each other may feel a bit weird and awkward to the clinician who is new to this type of work. Keeping track of the different alters who present with different ages and characteristics, including different developmental levels, behaviors, body posture, tone of voice, affects, skill level, and memories etc., often challenges our own sense of reality and at times can be disorganizing to the clinician. This is especially true when an angry alter becomes confrontational.

Not every clinician will accept the challenge to learn new skills and treat these disorders. Other clinicians may work in agencies where even if the patient is correctly diagnosed, appropriate treatment programs are not available due to the political nature or the cultural climate. But, for those clinicians who are able to accept the challenge to treat patients with DID and DDNOS, this research has identified the necessity for the clinician to recognize fluctuations in their own mental state and energy level and to provide self-care so that they are up to the task. A method of self-care might be getting support from the professional community.

While I was fortunate to have access to respected psychoanalytically trained mentors in both my professional life and my academic endeavors, finding a local community of professionals who believe in the disorders and who were knowledgeable of the appropriate treatment stages was lacking. I was often left with many questions about

DID and DDNOS and wished that I could find a simple to understand, yet, comprehensive manual to turn to for answers. It was the quest for this knowledge that was the inspiration and catalyst that began the long and arduous journey and the development of the *continuum construction theory.*

It is my hope that this study has raised awareness that the prevalence of child abuse in North America has reached epidemic proportions, with no end in sight.

Just as there are many challenges in working with patients with DID and DDNOS, there are also many benefits. Many of us chose the mental health profession with great anticipation that we will make a difference in a suffering person's life and we want to see change happen quickly, especially in a managed care environment. We want to provide kind and thoughtful care and promote growth and healing in our patients. In similar fashion, we also want our patients to see us as compassionate, caring, respectful and competent clinicians. Our patients are looking for hope. They are looking for a cure, often after many years of suffering. Perhaps this work will contribute to the clinician's feelings of gratification and help provide relief or a cure to the patient's suffering.

APPENDIX A: LETTER OF INVITATION TO PARTICIPANTS

April 15, 2011

Dear _____,

This letter is a follow-up to our phone conversation when I invited you to be a Participant in my research study. As you know from our years of working together in a therapeutic relationship, I have been pursuing a PhD in Clinical Social Work at The Sanville Institute in Berkeley, CA and I have finally reached the dissertation phase of the program. The clients invited to participate in this study have been determined to meet the following criteria: 1) must have reported on early childhood experiences that suggest an insecure attachment to the primary mother figure, 2) must have reported early childhood experiences of abuse by familial or non-familial persons, and 3), must have reported symptoms suggestive of a dissociative disorder, including losing time or amnesia, 4) must have been diagnosed with a dissociative disorder by this researcher.

You have been invited to participate in the research study by allowing me to use information from your case file for this study with the agreement that ***your identity will be kept anonymous and your confidentiality protected.*** The attached *Informed Consent* form fully explains the risks of participation, the benefits, and the many measures that are being taken not only to insure confidentiality, but also to provide for your emotional well being as a Participant in my research study. As a result of many years of researching the field of child abuse and dissociative disorders, disorders that often lead to many years of suffering beginning in early childhood, this study has identified a new theory titled, *The Continuum Construction Theory: A New Understanding of the Causation and Construction of Multiple Personalities in Persons with Dissociative Identity Disorder.* The attached Informed Consent form will provide more details about the study.

I thank you very much for your consideration in allowing me the opportunity to present your case material in my dissertation.

Please return the Informed Consent signed and dated in the envelope provided at your earliest convenience.

Sincerely yours,

Rosalind Monahan, LCSW

APPENDIX B: INFORMED CONSENT FORM

I, _____, hereby willingly consent to
. (print name of research participant)

participate in the study: THE CONTINUUM CONSTRUCTION THEORY: A NEW UNDERSTANDING OF THE CAUSATION AND CONSTRUCTION OF MULTIPLE PERSONALITIES IN PERSONS DIAGNOSED WITH DISSOCIATIVE IDENTITY DISORDER. This doctoral research project

will be conducted by ROSALIND MONAHAN, LCSW under the direction

of ELINOR DUNN GRAYER, PhD, Principle Investigator and faculty member, and under the auspices of The Sanville Institute.

I understand that I am one of a number of clients selected for participation in this study by meeting the following criteria: 1) must have reported on early childhood experiences that suggest an insecure attachment to the primary mother figure, 2) must have reported early childhood experiences of abuse by familial or non-familial persons, 3), must have reported symptoms suggestive of a dissociative disorder, including losing time or amnesia, and 4) must have been diagnosed with a dissociative disorder by the researcher conducting this study.

I understand that my participation in this study involves the following: 1) granting permission to have my case material analyzed by the researcher and disclosed in a publication to illustrate a new theory being proposed by the researcher, 2) having opportunity to review a draft of any material proposed for disclosure from my case file before approving the disclosure via this consent form, 3) at my request, to have the case material proposed for disclosure mailed to me for review before approving the disclosure via this consent form, or 4) at my request, to have an appointment to review the case material to be disclosed with the researcher at no cost to me before or after signing the consent form, and 5) at my request, to receive a copy of the research study after publication, which will be provided to me at no cost by contacting the researcher. Apart from authorizing the use and disclosure of my personal information as previously described, there are no additional requirements for participation in this study.

I understand that all information from my case file used in this study will be disguised to protect my confidentiality. I also understand that my name on the consent form well be kept confidential and will be known only to the researcher, Rosalind Monahan, and that the form will be kept in my case file in the researcher's office. Additional provisions to protect my confidentiality are described below.

I understand that the potential risks of my participation may include having sensitive personal information from my therapeutic record made public in a professional document even when the information is disguised and my identity is protected. I understand that the final document

contains not only case material from my file, but from other patient's files that could trigger troublesome emotional responses in me should I choose to read the final publication.

I understand that the following measures will be offered to me if I experience even minimal emotional and/or physical discomfort by participating in the research study: 1) an emergency consult by calling the researcher's cell phone, 2) and appointment to meet with the researcher in her office to discuss any concerns or discomfort, 3) up to four free 50-minute office sessions to help stabilize me, 4) education about the contents of the dissertation and the new theory, 5) information about the purpose and rational of the study, and 6) further reassurance about how my confidentiality will be protected.

I understand that Ms. Monahan, the research investigator, will follow professional guidelines for disguising client information when writing her dissertation to minimize the previously stated confidentiality risks to me and to assure that my personal identity will not be revealed in the document. These guidelines for disguising client information for publication were taken from a research survey of professional authors who have published articles in distinguished peer reviewed journals in the related fields. I further understand that the Sanville Institute faculty supervising Ms. Monahan will review the document to assure that the previously described steps to protect my identity have been followed.

Based on the professional guidelines, the following information that will be omitted in the dissertation includes: my real name; age; level of education; my geographical location; my place or type of employment; and any specific employment history. Information about my family background will either be omitted or significantly disguised to prevent identification of me, of my family members, and of any individuals discussed in session. Information about me, my family or associates that may reveal my identity when taken together with other information used in the document will not be included.

The potential benefits of my participation in this study include, but are not limited to the following: 1) knowing that I have been invited to contribute to research that may further understanding of dissociative disorders, specifically Dissociative Identity Disorder (DID) and Dissociative Identity Disorder Not Otherwise Specified (DDNOS), 2) realizing that I may be contributing to helping other patients, perhaps of a much younger age, so that they may not have to endure years of suffering, 3) knowing that future clinicians may have an opportunity to improve their abilities to provide treatment to patients with DID or DDNOS, and 4) knowing that I may be contributing to the professional community's acknowledgement that child abuse is of epidemic proportions in North America and interventions need to happen early in a child's life.

I understand that Ms. Monahan's dissertation is a scholarly work that will be maintained by the Sanville Institute library and that it will be made available upon request to professionals and scholars interested in the study of mental health problems and their treatment. By signing this authorization I agree to this use and disclosure of my clinical information.

INFORMED CONSENT FORM

My signature below indicates that I have read the above explanation about my participation in this research study, that I understand the procedures involved and that I voluntarily agree to participate.

Signature:_____

Date_____

If you would like a copy of the results of this study, please provide your name and address:

Name_____

Address_____

APPENDIX C: PROTECTION OF RESEARCH PARTICIPANTS APPROVAL

THE SANVILLE INSTITUTE
PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

Title of Research Project "The Continuum Construction Theory: A New Understanding of the Causation and Construction of Multiple Personalities in Persons Diagnosed with Dissociative Identity Disorder.

Principal Investigator: ELINOR D. GRAYER, PhD
(print name and degree)

Investigator: Rosalind Monahan, LCSW
(print name)

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the Student and Faculty Handbook), and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study (check one)

_____ Are not "at risk."

__✓__ May be considered to be "at risk," and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights.

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Elinor D Grayer, PhD 4-1-11
(signature of principal investigator/date)

Rosalind Monahan, LCSW 4-1-11
(signature of investigator/date)

Action by the Committee on the Protection of Research Participants:

Approved ✓ Approved with Modifications _____ Rejected _____

Stephanie Grossman Ph.D. Date 4-14-11
Signature of representative of the Committee on the Protection of Research Participants/date

Richard M Ramsey 4-14-11
(signature of dean & date)

REFERENCES

Aarens, M., Cameron, T., Roizen, J., Roizen, R., Room, R., Schneberk, & Wingard, D. (1978). *Alcohol, causalities and crime.* Berkeley, CA; Social Research Group.

Abend, S. M. (1986). Sibling loss. In A. Rothstein (Ed.), *The reconstruction of trauma* (95-104). Madison, CT: International Universities Press.

Ainsworth, M. D. S. (1967). *Infancy in Uganda: Infant care and the growth of attachment.* Baltimore, MD: Johns Hopkins University Press.

Alexander, P. C., & Anderson, C. L (1994). An attachment approach to psychotherapy with the incest survivor. *Psychotherapy*, 31, 665-675.

Allen, J. G. (2001). *Traumatic relationships and serious mental disorders.* New York, NY: Wiley.

Allen, J. P., & Land, D. (1999). Attachment in adolescence. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 319-335). New York: Guilford Press.

Alpher, V. S. (1996). Identity and introject in dissociative disorders. *Journal of Consulting and Clinical Psychology, 64*, 1238-1244.

Alvarado, C. (1991). Iatrogenesis and dissociation: A historical note. *Dissociation, 4*(1), 36-38.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders (*3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987a). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association (1987b). *Quick reference to the Diagnostic Criteria from DSM-II-R* (2nd printing, June, 1987). Washington, DC: American Psychiatric Press.

American Psychiatric Association. (2000a). *Desk reference to the diagnostic criteria from DSM-IV-TR.* Washington, DC: Author.

American Psychiatric Association. (2000b). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Andrews, B. (2002). Body shame and abuse in childhood. In P. Gilbert & J. Miles (Eds.), *Body shame; Conceptualization, research and treatment* (pp. 256-266). New York, NY: Brunner-Routledge.

Armsworth, M. T., Stronk, K., & Carlson, C. D. (1999). Body image and self-perception in women with histories of incest. In J. Goodwin & R. Attias (Eds.), *Splintered reflections: Images of the body in trauma* (pp. 137-153). New York, NY: Basic Books.

Baita, S. (2011). Dalma (4-7 years old) —"I've got all my sisters with me." Treatment of dissociative identity disorder in a sexually abused young child. In S. Wieland (Ed.), *Dissociation in traumatized children and adolescents* (pp. 29-73). New York, NY: Routledge.

Bakal, D. (1999). *Minding the body: Clinical uses of somatic awareness*. New York, NY: Guilford Press.

Baldwin, M. W. (1992). Relational schemas and the processing of social information. *Psychological Bulletin, 112*, 461-484.

Balint, M. (1979). *The basic fault*. New York, NY: Brunner/Mazel.

Barlow, M. R., & Freyd, J. J. (2009). Adaptive dissociation: Information processing and response to betrayal. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 93-105). New York, NY: Routledge.

Basham, K. (2008). Trauma theories. In J. Berzoff, L. Melano Flanagan, & P. Hertz (Eds.), *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (pp. 411-441). Lanham, MD: Jason Aronson.

Baum, E. A. (1978). Imaginary companions of two children. *Journal of the American Academy of Child Psychiatry, 17*, 324-330.

Beere, D .B. (2009). Dissociative perceptual reactions: The perceptual theory of dissociation. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 209-222). New York, NY: Routledge.

Bliss, E. L. (1980). Multiple personalities: A report of 14 cases with implications for schizophrenia and hysteria. *Archives of General Psychiatry, 37*, 1388-1397.

Bliss, E. L. (1984). Spontaneous self-hypnosis in multiple personality disorder. *Psychiatric Clinics of North America, 7*, 135-148.

Bliss, E. L. (1986). *Multiple personality, allied disorders and hypnosis*. New York, NY: Oxford University Press.

Blizzard, R. A. (2001). Masochistic and sadistic ego states: Dissociative solutions to the dilemma of attachment to an abusive caretaker. *Journal of Trauma and Dissociation, 2*(4), 37-58.

Blizzard, R. A. (2003). Disorganized attachment: Development of dissociated self-states and a relational approach to treatment. *Journal of Trauma and Dissociation, 4*, 27-50.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation, anxiety and anger.* New York, NY: Basic Books.

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London, England: Tavistock.

Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss, sadness and depression.* New York, NY: Basic Books.

Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment.* New York, NY: Basic Books. (Original work published 1969)

Bowlby, J. (1984). *Attachment and loss* [Audiotapes 1 & 2]. Los Angeles, CA: Lifespan Learning Institute.

Bowlby, J. (1988). *A secure base: Parent-child: Attachment and healthy human development.* New York, NY: Basic Books.

Braid, J. (1843). *Neurypnology or the rationale of nervous sleep considered in relation to animal magnetism.* London, England: J. Churchill.

Braude, S. E. (2009). The conceptual unity of dissociation: A philosophical argument. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 27-36). New York, NY: Routledge.

Braun, B. G. (1984). Towards a theory of multiple personality and other dissociative phenomena. *Psychiatric Clinics of North America, 7*(1), 171-193.

Braun, B. G. (1986). Introduction. In *Treatment of multiple personality disorder* (pp. xi-xxi). Washington, DC: American Psychiatric Press.

Braun, B. G. (1988). The BASK (Behavior, Affect, Sensation, Knowledge) model of dissociation. *Dissociation, 1*(1), 4-23.

Braun, B. G., & Sachs, R. G. (1985). The development of multiple personality disorder: Predisposing, precipitating, and perpetuating factors. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 37-64). Washington, DC: American Psychiatric Press.

Bremner, J. D. (2009). Neurobiology of dissociation: A view from the trauma field. In P. F. Dell & J. A. O'Neil (Eds.), Dissociation and the dissociative disorders (pp. 329-336). New York, NY: Routledge.

Brenner, C. (1986). Discussion of the various contributions. In A. Rothstein (Ed.), *The reconstruction of trauma* (pp. 195-203). Madison, CT: International University Press.

Bretherton, I. (1990). Open communication and internal working models: Their role in the development of attachment relationships. In R. A. Thompson (Ed.), *Nebraska Symposium on Motivation: Vol. 36. Socioemotional development* (pp. 59-113). Lincoln: University of Nebraska.

Bretherton, I., & K. A. Munholland. (1999). Internal working models in attachment relationships: A construct revisited. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical application* (pp. 89-111). New York, NY: Guilford Press.

Breuer, J., & Freud, S. (1955). Studies on hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 1-312). London, England: Hogarth Press. (Original work published 1895).

Brewin, C. R. (2001). A cognitive neuroscience account of posttraumatic stress disorder and its treatment. *Behavioral Research and Therapy, 39*, 373-393.

Briere, J. (1992). Methodological issues in the study of sexual abuse effects. *Journal of Consulting and Clinical Psychology, 60*, 196-203.

Brown, D., Scheflin, A., & Hammond, D. C. (1998). *Memory, trauma treatment and the law*. New York, NY: Norton.

Bryant, R., Moulds, M. L., & Nixon, R. D. V. (2002). Cognitive therapy of acute stress disorder: A four-year follow-up. *Behaviour Research and Therapy, 36*, 1091-1099.

Cardena, E., & Spiegel, D. (1996). Diagnostic issues, criteria and co-morbidity of dissociative disorders. In L. Michelson & W. J. Ray, (Eds.), *Handbook of dissociation: Theoretical, empirical and clinical perspectives* (pp. 227-250). New York, NY: Basic Books.

Carlson, E. A. (1998). A prospective longitudinal study of disorganized/disoriented attachment. *Child Development, 69*(4), 1107-1128.

Carlson, E. A., Cicchetti, D., Barnett, D., & Braunwald, K. (1989). Disorganized/disoriented attachment relationships in maltreated infants. *Developmental Psychology, 25,* 525-531.

Carlson, E. A., & Sroufe, L. A. (1995). The contribution of attachment theory to developmental psychopathology. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental Psychopathology* (Vol. 1, pp. 581-617). New York, NY: Wiley.

Carlson, E. A., Tuppett, M., Yates, L. & Sroufe, L. A. (2009). Dissociation and development of the self. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 39-52). New York, NY: Routledge.

Carlson, E. B. (1997). *Trauma assessments: A clinician's guide*. New York, NY; Guilford Press.

Carpenter, W. B. (1884). *Principles of mental physiology* (4th ed.). New York, NY: Appleton.

Cassidy, J. (1999). The nature of the child's ties. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical application* (pp. 3-20). New York, NY: Guilford Press.

Chu, J. A. (1998). *Rebuilding shattered lives: The responsible treatment of complex post-traumatic and dissociative disorders*. New York, NY: Wiley.

Clary, W., Burstein, K., & Carpenter, J. (1984). Multiple personality and borderline personality disorder. *Psychiatric Clinics of North America, 7*, 89-100.

Cormier, J. F., & Thelen, M. H. (1998). Professional skepticism of multiple personality disorder. *Professional Psychology: Research and Practice, 29*, 163-167.

Courtois, C. A. (1999). *Recollections of sexual abuse: Treatment principles and guidelines*. New York, NY: Norton.

Cox, B. J., Clark, I. P., & Enns, M. W. (2002). Posttraumatic stress disorder and the structure of common mental disorders. *Depression and Anxiety, 15*, 168-171.

Crabtree, A. (1993). *From Mesmer to Freud: Magnetic sleep and the roots of psychological healing. New Haven,* CT: Yale University Press.

Craine, L. S., Henson, C. E., Colliver, J. A., & MacLean, D. G. (1988). Prevalence of a history of sexual abuse among female psychiatric patients in a state hospital system. *Hospital Community Psychiatry, 39*(3), 300-304.

Crittenden, P. (1995). Attachment and psychopathology. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social development, and clinical perspectives* (367-406). Hillsdale, NJ: Analytic Press.

Crooks, C. V., & Wolfe, D. A. (2007). *Child abuse and neglect.* In Eric J. Mash & Russell A. Barkley (Eds.), *Assessment of childhood disorders* (4th ed., pp. 639-684). New York, N.Y: Guilford Press.

Dalenberg, C. J. (2000). *Countertransference and the treatment of trauma.* Washington, DC: American Psychological Association.

Damaiso, A. (1999). *The feeling of what happens: Body and emotion in the making of consciousness.* New York, NY: Harcourt Brace.

Davies, J. M., & Frawley, M. G. (1994). *Treating the adult survivor of childhood sexual abuse.* New York, NY: Basic Books.

Dell, P. F. (2001). Why the diagnostic criteria for dissociative identity disorder should be changed. *Journal of Trauma & Dissociation, 2*(1), 7-37.

Dell, P. F. (2009). The phenomenology of pathological dissociation. In P. R. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 225-237. New York, NY: Routledge.

Dell, P. F., & O'Neil, J. A. (2009). *Dissociation and the dissociative disorders.* New York, NY: Routledge.

Diamond, S., Balvin, R., & Diamond, F. (1963). *Inhibition and choice.* New York, NY: Harper & Row.

Dowling, S. (1986). Discussion of the various contributions. In A. Rothstein (Ed.), *The reconstruction of trauma* (pp. 205-218). Madison, CT: International University Press.

Dozier, M. K., Chase S., & K. E. Albus. (1999). Attachment and psychopathology in adulthood. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical application* (pp. 497-519). New York, NY: Guilford Press.

Dunn, G. E., Paolo, A. M., Ryan, J. J., & Van Fleet, J. N. (1994). Belief in the existence of multiple personality disorder among psychologists and psychiatrists. J*ournal of Clinical Psychology, 50*(3), 454-457.

Edwards, V. J., Anda, R. F., Dube, A. R., Long, M., Chapman, D. P., & Felitti, V. J. (2005). The wide-ranging health outcomes of adverse childhood experiences. In K. A. Kendall-Tackett & S. M. Giacomoni (Eds.), *Child victimization* (pp. 8.1–8.16). Kinsgton, NJ: Civic Research Institute.

Elicker, J., Englund, M., & Sroufe, L. A. (1992). Predicting peer competence and peer relationships in childhood from early parent-child relationships. In R. Parke & G. Ladd (Eds.), *Family-peer relationships: Models of linkage* (pp. 77-106). Hillsdale, NJ: Erlbaum.

Ellenberger, H. (1970). *The discovery of the unconsciousness: The history and evolution of dynamic psychology.* New York, NY: Basic Books.

Emde, R. (1971). Stress and neonatal sleep. *Psychosomatic Medicine, 33,* 491-497.

Engel, G. (1961). "Is grief a disease?" *Psychosomatic Medicine, 23,* 18-22.

Fagan, J., & McMahon, P. (1984). Incipient multiple personality in childhood. *Journal of Nervous and Mental Disease, 172*, 26-36.

Fahy, T. A. (1988). The diagnosis of multiple personality disorder: A critical review. *British Journal of Psychiatry, 153*, 597-606.

Fairbairn, W. R. D. (1943). The repression and return of bad objects. In *Psychoanalytic studies of the personality* (59-81). London: Tavistock/Routledge.

Fairbairn, W. R. D. (1944). Endopsychic structure considered in terms of object-relationship. In D. E. Scharff & E. F. Birtle (Eds.), *W. R. D. Fairbairn: Psychoanalytic studies of the personality* (pp. 82-132). London, England: Routledge.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis*. New York, NY: Norton.

Ferenczi, S. (1949). Confusion of tongues between the adult and the child. *International Journal of Psychoanalysis, 30,* 225-230. (Original work published 1933)

Fergusson B. M., & Mullen, P. E. (1999). *Childhood sexual abuse: An evidenced-based perspective.* Thousand Oaks, CA: Sage.

Figley, C. (1995). *Compassion fatigue: Coping with secondary stress disorder in those who treat the traumatized.* New York, NY: Brunner/Mazel.

Figley, C. (2008). Compassion fatigue. *Journal of Faith & Therapy, 2*(4), 1-4.

Fine, C. G. (1990). The cognitive sequelae of incest. In R. P. Kluft (Ed.), *Incest-related syndromes of adult psychopathology* (pp. 161-182). Washington, DC: American Psychiatric Press.

Fine, C. G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of the multiple personality disorder patient. *Psychiatric Clinics of North America, 14,* 661-676.

Fine, C. G., & Comstock, C. M. (1989). The completion of cognitive schemata and affective realms through the temporary blending of personalities. Paper presented at the *Fifth International Conference on Multiple Personality/Dissociative States.* Chicago, Il.

Finkelhor, D. (1979). *Sexually victimized children.* New York, NY: Free Press.

Finkelhor, D., & Baron, L. (1986). High-risk children. In D. Finkelhor, S. Araji, A. Browne, S. Peters, & G. Wyatt, (Eds.), *A sourcebook on child sexual abuse* (pp. 43-71). Beverly Hills, CA: Sage.

Fisher, S., & Cleveland, S. (1958). *Body image and personality.* Princeton, NJ: Van Nostrand.

Fleming, J., Mullen, P., & Bammer, G. (1997). A study of potential risk factors for sexual abuse in childhood. *Child Abuse and Neglect, 21*, 49-58.

Fonagy, P. (1999). Psychoanalytic theory from the viewpoint of attachment theory and research. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 595-625). New York, NY: Guilford Press.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self.* New York, NY: Other Press.

Foote, B., Smolin, Y., Neft, D. I., & Lipschitz, D. (2008). Dissociative disorders and suicidality in psychiatric outpatients. *Journal of Nervous & Mental Disease, 196*(1), 29-36.

Ford, J. (1999). Disorder of extreme stress following war-zone military trauma: Associated features of posttraumatic stress disorder or comorbid but distinct syndromes? *Journal of Consulting and Clinical Psychology, 67*, 3-12.

Ford, J. D. (2009). Dissociation in complex posttraumatic stress disorder or disorders of extreme stress not otherwise specified. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 471-483). New York, NY: Routledge.

Forrest, D. (1999). *The evolution of hypnotism.* Forfar, Scotland: Black Ace Books.

Fosha, D. 2000). *The transforming power of affect: A model for accelerated change.* New York, NY: Basic Books.

Fraiberg, S. (1982). Pathological defenses in infancy. *Psychoanalytic Quarterly, 41*, 61-635.

Fraser, G. A. (2003). Fraser's "Dissociative Table Technique" revisited, revised: A strategy for working with ego states in dissociative disorders and ego-state therapy. *Journal of Trauma & Dissociation, 4*(4), 5-28.

Freud, S. (1905). Three essays on the theory of sexuality. In J. Strachey, (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 135-243). London, England: Hogarth Press.

Freud, S. (1917). Introductory lectures on psycho-analysis, Part III. *Standard edition* (Vol. 16, pp. 243-463).

Freud, S. (1926). Inhibitions, symptoms, and anxiety. *Standard edition* (Vol. 20, pp. 87-172.

Freud, S. (1952). The interpretation of dreams. In R. M. Hutchins & M. J. Adler (Eds.), *The major works of Sigmund Freud*, (pp. 135-398). Chicago, Il: Encyclopaedia Britannica. (Original work published in 1900)

Freud, S. (1955). Beyond the pleasure principle. *Standard edition* (Vol. 18, pp. 3-143). (Original work published 1920)

Freyd, J. (1994). Betrayal trauma: Traumatic amnesia as an adaptive response to childhood abuse. *Ethics and Behavior, 4*(4), 307-329.

Freyd, J., Klest, B., & Allard, C. (2005). Betrayal trauma: Relationship to physical health, psychological distress, and a written disclosure intervention. *Journal of Trauma & Dissociation, 6*(3), 83-104.

Friedman, M. J., Resick, P. A., & Keane, T. M. (2007). Twenty-five years of progress and challenges. In M. J. Freidman, T. M. Keane, & P. A. Resick, *Handbook of PTSD: Science and practice* (pp. 3-18). New York, NY: Guildford Press.

George, C., & Solomon, J. (1999). Attachment and caregiving: The caregiving behavioral system. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical application* (pp. 649-670). New York, NY: Guilford Press.

Gil, S. (2009). The therapist as psychobiological regulator: Dissociation affect attunement and clinical process. *Clinical Social Work Journal, 38*(3), 1-9. doi:10.1007/s10615-009-0213-5

Gil, M. M., & Brenman, M. (1959). Hypnosis and related states: Psychoanalytic studies in regression. Madison, CT: International Universities Press.

Gilbert, P. (2002). Body shame: A biopsychosocial conceptualization and overview with treatment implications. In P. Gilbert & J. N. V. Miles (Eds.), *Body shame: Conceptualization, research & treatment* (pp. 3-54). Hove, England: Brunner-Routledge.

Gold, S., & Seibel, S. L. (2009). Treating dissociation: A contextual approach. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 625-636). New York, NY: Routledge.

Goldman, J. (2010). It's one thing to treat, it's another thing to promote awareness. *International Society for the Study of Trauma and Dissociation Newsletter,* 1st quarter, 13.

Goodwin, J. (1985). Credibility problems in multiple personality disorder patients and abused children. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 1-19). Washington, DC: American Psychiatric Press.

Goodwin, J. M., & Attias, R. (1999). *Splintered reflections: Images of the body in trauma.* New York, NY: Basic Books.

Greaves, G. B. (1993). A history of multiple personality disorder. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 355-380). Washington, DC: American Psychiatric Press.

Green, A. H. (1996a). Overview of child sexual abuse. In S. J. Kaplan (Ed.), *Family violence: A clinical and legal guide* (pp. 73-104). Washington, DC: American Psychiatric Press.

Greenacre, P. (1949). A contribution to the study of screen memories. In *Trauma growth and personality* (pp. 188-203). Madison, Ct: International Universities Press.

Greenacre, P. (1952). The prepuberty trauma in girls. In *Trauma growth, and personality* (pp. 204-223). New York, NY: Norton

Greenacre, P. (1967). The influence of infantile trauma in genetic patterns. In S. S. Furst, (Ed.), *Psychic trauma* (pp. 108-153). Madison, Ct: International Universities Press

Greenberg, M. T. (1999). Attachment and psychopathology in childhood. In J. Cassidy and P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 469-496). New York, NY: Guilford Press.

Greenberg, M. T., Speltz, M. L., & De-Klyen, M. (1993). The role of attachment in the early development of disruptive behavior problems. *Development and Psychopathology 5,* 191-213.

Gregory, R. (Ed.). (1987). *The Oxford companion of the mind.* (477-478). New York, NY: Oxford University Press.

Guntrip, H. (1971). *Psychoanalytic theory, therapy, and the self.* New York, NY: Basic.

Hacking, I. (1995). *Rewriting the soul: Multiple personality and the sciences of memory.* Princeton, NJ: Princeton University Press.

Harper, K., & Steadman, J. (2003). Therapeutic boundary issues in working with childhood sexual-abuse survivors. *American Journal of Psychotherapy, 57,* 64-79.

Heim, D., & Buhler. K. (2006). Psychological trauma and fixed ideas in Pierre Janet's conception of dissociative disorders. *American Journal of Psychotherapy, 2,* 111-126.

Heinicke, C. M. (1956). Some effects of separating two-year-old children from their parents: A comparative study. *Human Relations, 9,* 105-76.

Heinicke, C., & Westheimer, I. (1966). *Brief separations.* New York, NY: International Universities Press.

Herman, J. (1992). *Trauma and recovery.* New York, NY: Basic Books.

Hilgard, E. R. (1973). Dissociation revisited. In M. Henle, J. Janynes, & J. J. Sullivan (Eds.), *Historical conceptions of psychology* (pp. 205-219). New York, NY: Springer.

Hilgard, E. R. (1974). Toward a neo-dissociation theory: Multiple cognitive controls in human functioning. *Perspectives in Biology and Medicine, 17*, 301-316.

Hilgard, E. R. (1977). *Divided consciousness: Multiple controls in human thought and action.* New York, NY: Wiley.

Hilgard, E. R. (1986). *Divided consciousness: Multiple controls in human thought and action.* (Expanded ed.). New York, NY: Wiley-Interscience.

Hilgard, E. R. (1994). Neo-dissociation theory. In S. J. Lynn & J. W. Rhue (Eds.), *Dissociation: Clinical and theoretical perspectives* (pp. 32-51). New York, NY: Guilford Press.

Horevitz, R. P. (1996). The treatment of a case of dissociative identity disorder. In S. J. Lynn, I. Kirsch, & J. W. Rhue (Eds.), *Casebook of clinical hypnosis* (pp. 193-222). Washington, DC: American Psychological Association.

Horevitz, R. P., & Braun, B. G. (1984). Are multiple personalities borderline? *Psychiatric Clinics of North America, 7*, 69-87.

Hornstein, N. L., & Tyson, S. (1991). Inpatient treatment of children with multiple personality/dissociative disorders and their families. *Psychiatric Clinics of North American, 24*, 631-648.

Houchberg-Shusta, S. (2004). Therapeutic hazards of treating child alters as real children in dissociative identity disorder. *Journal of Trauma & Dissociation, 5*(1), 13-27.

Howell, E. (2005). *The dissociative mind.* Mahwah, NJ: Analytic Press.

International Society for the Study of Dissociation (ISSD). (2005). [Chu, J. A., Loewenstein, R., Dell, P. F., Barach, P. M., Somer, E., Kluft, R. P., . . . Howell, E.] Guidelines for treating dissociative identity disorder in adults. *Journal of Trauma and Dissociation, 6*(4), 69-149. doi:10.1300/J229v06n04_05

International Society for the Study of Trauma and Dissociation (ISSTD). (2010). *Frequently asked questions: Trauma and dissociation.* Retrieved from http://www.isst-d.org/education/faq-index.htm

James, W. (1890). *Principles of psychology.* New York, NY: Dover.

Janet, P. (1925). *Principles of psychotherapy.* London, England: Allen & Unwin. (Original work published 1919)

Janoff-Bulman, R., Timko, C., & Carli, L. (1985). Cognitive biases in blaming the victim. *Journal* of *Experimental Social Psychology, 21,* 161-177.

Juhan, D. (1987). *Job's body: A handbook for bodywork.* Barrytown, NY: Station Hill Press.

Kahn, L. (2006). The understanding and treatment of betrayal trauma as a traumatic experience of love. *Journal of Trauma Practice, 5*(3), 1-7.

Kampman, R. (1976). Hypnotically induced multiple personality: An experimental study. *International Journal of Clinical and Experimental Hypnosis, 24*, 215-227.

Kardag, F., Sar, V., Tamar-Gurol, D., Evren, C., Karagoz, M., & Erkiran, M. (2005). Dissociative disorders among inpatients with drug or alcohol dependence. *Journal of Clinical Psychiatry, 66*(10), 1247-1253.

Kenny, M. G. (1986). *The passions of Ansel Bourne*. Washington, DC: Smithsonian Institution Press.

Kepner, J. (1987). *Body process: A gestalt approach to working with the body in psychotherapy*. New York, NY: Gardner Press.

Kepner, J. (1995). *Healing tasks: Psychotherapy with adult survivors of childhood abuse.* San Francisco, CA: Jossey-Bass.

Kihlstrom, J. F. (1984). Conscious, subconscious, unconscious: A cognitive perspective. In K. S. Bowers (Ed.), *The unconscious reconsidered* (pp. 149-311). New York, NY: Wiley.

Kinsler, P. J. (1992). The centrality of the therapeutic relationship: What's *not* being said. *Dissociation, 5*(3), 166-170.

Kirsch, I. & Lynn, S. J. (1995). The altered state of hypnosis: Changes in the theoretical landscape. *American Psychology, 50*, 846-858.

Kluft, R. P. (1984). Multiple personality in childhood. *Psychiatric Clinics of North America, 7*(1), 121-134.

Kluft, R. P. (1985a). Childhood multiple personality disorder: Predictors, clinical findings, and treatment results. In *Childhood antecedents of multiple personality* (pp. 168-196). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1985b). The natural history of multiple personality disorder. In *Childhood antecedents of multiple personality* (pp. 197-238). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1987). An update on multiple personality disorder. *Hospital and Community Psychiatry, 38*, 363-372.

Kluft, R. P. (1988a). The dissociative disorders. In J. Talbot, R. Hales, & S. Yudofsky, *The American psychiatric press textbook of psychiatry* (pp. 557-585). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1988b). The phenomenology and treatment of extremely complex multiple personality disorder. *Dissociation, 1*(4), 47-57.

Kluft, R. P. (1989). Playing for time: Temporizing techniques in the treatment of multiple personality disorder. *American Journal of Clinical Hypnosis, 32*, 90-98.

Kluft, R. P. (1990a). Dissociation and subsequent vulnerability. *Dissociation, 3*(3), 167-173.

Kluft, R. P. (1990b). Incest and subsequent revictimization: The case of therapist-patient sexual exploitation, with a description of the sitting duck syndrome. In *Incest-related syndromes of adult psychopathology* (pp. 263-287). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1990c). On the apparent invisibility of incest: A personal reflection on things known and forgotten. In *Incest-related syndromes of adult psychopathology* (pp.11-34). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1993a). Clinical approaches to the integration of personalities. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 101-133). Washington, D.C.: American Psychiatric Press.

Kluft, R. P. (1993b). The initial stages of psychotherapy in the treatment of multiple personality disorder patients. *Dissociation, 6*(2/3), 145-161.

Kluft, R. P. (1995). Current controversies surrounding dissociative identity disorder. In L. Cohen, J. Berzoff, & M. Elin (Eds.), *Dissociative identity disorder* (pp. 347-377). Northvale, NJ: Jason Aronson.

Kluft, R. P. (1996). Treating the traumatic memories of patients with dissociative identity disorder. *American Journal of Psychiatry, 153*, 103-110.

Kluft, R. P. (1999). An overview of the psychotherapy of dissociative identity disorder. *American Journal of Psychotherapy, 53*, 289-319.

Kluft, R. P. (2011). Foreword. In S. Wieland (Ed.), *Dissociation in traumatized children and adolescents* (pp. xi-xvi). New York, NY: Routledge.

Kluft, R. P., Steinberg, M., & Spitzer, R, (1988). DSM-III revision in the dissociative disorders: An explanation of the observation and rational. *Dissociation, 1*, 39-46.

Kobak, R. (1999). The emotional dynamics of disruptions in attachment relationships: Implications for theory, research, and clinical Intervention. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical application* (pp. 21-43). New York, NY: Guilford Press.

Krakauer, S. Y. (2001). *Treating dissociative identity disorder: The power of the collective heart.* Ann Arbor, MI: Taylor and Francis.

Kramer, S. (1990). Residues of incest. In H. B. Levine (Ed.), *Adult analysis and childhood sexual abuse* (149-170). Hillsdale, NJ: The Analytic Press.

Kramer, S. (1991). Psychopathological effects of incest. In S. Kramer & S. Akhtar (Eds.), *The trauma transgression* (pp. 1-12). Northvale, NJ: Jason Aronson.

Kris, E. (1950). Notes on the development and on some current problems of psychoanalytic child psychology. *Psychoanalytic Study of the Child, 5*, 24-46.

Krystal, H. (1988). Integration and self healing. Hillsdale, NJ: The Analytic Press.

Kurtz, R. (1990). *Body-centering psychotherapy: The Hakomi method.* Mendicino, CA: LifeRhythms.

Kurtz, R., & Prestera, H. (1976). *The body reveals: An illustrated guide to the psychology of the body.* New York, NY: Holt, Rinehart, & Winston.

Lalonde, J. K., Hudson, J. I., Gigante, R. A., & Pope, H. G. (2001). Canadian and American psychiatrists' attitudes toward dissociative disorders diagnosis. *Canadian Journal of Psychiatry, (46)*5, 407-412.

Laub, D., & Auerhan, N. C. (1989). Failed empathy – a central theme in the survivor's holocaust expressions. *Psychoanalytic Psychology, 6*, 377-400.

Lazrove, S., & C. G. Fine. (1996). The use of EMDR in patients with dissociative identity disorder. *Dissociation, 9*(4), 289-299.

Lemke, W. (2007). Fostering internal cooperation through the use of imagery in the treatment of dissociative identity disorder. *Journal of Trauma & Dissociation, 8*(4), 53-68.

Levine, H. B. (Ed.). (1990). *Adult analysis and childhood sexual abuse.* Hillsdale, NJ: The Analytic Press.

Levine, P. A. (1997). *Walking the tiger: The innate capacity to transform overwhelming experiences.* Berkeley, CA: North Atlantic Books.

Levine, P. (2004). Panic, biology, and reason: Giving the body its due. In I. Macnaughton (Ed.), *Body, breath, and consciousness: A somatics anthology* (pp. 267-286). Berkeley, CA: North Atlantic Books.

Levine, P., & Macnaughton, I. (2004). Breath and consciousness: Reconsidering the viability of breathwork in psychological and spiritual interventions in human development. In I. Macnaughton (Ed.), *Body, breath, and consciousness: A somatics anthology* (pp. 367-394). Berkeley, CA: North Atlantic Books.

Liotti, G. (1992).Disorganized/disoriented attachment in the etiology of the dissociative disorders. *Dissociation, 5*(4), 196-204.

Liotti, G. (1995). Disorganized/disoriented attachment in the etiology of dissociative disorders. In R. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental and clinical perspectives* (pp. 343-363). Hillsdale, NJ: Analytic Press.

Liotti, G. (1999a). Disorganized attachment as a model for understanding of dissociative psychopathology. In J. Solomon & C. George (Eds.), *Attachment disorganization* (pp. 291-317). New York, NY: Guilford Press.

Liotti, G. (1999b). Understanding the dissociative process: The contributions of attachment theory. *Psychoanalytic Inquiry, 19*, 757-783.

Liotti, G. (2009). Attachment and dissociation. In P. F. Dell & J. O'Neill (Eds.), *Dissociation: DSM-V and beyond* (pp. 53-65). New York, NY: Routledge Press.

Lowen, A. (1970). *Pleasure: A creative approach to life.* Baltimore, MD: Penguin Books.

Lowenstein, R. (1993). Posttraumatic and dissociative aspects of transference and countertransference in the treatment of multiple personality disorder. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 51-85). Washington, DC: American Psychiatric Press.

Ludwig, A. M. (1983). The psychobiological functions of dissociation. *American Journal of Clinical Hypnosis, 26*, 93-99.

Lusk, R., & Waterman, J. (1986). Effects of sexual abuse on children. In K. MacFarlane & J. Waterman (Eds.), *Sexual abuse of young children: Evaluation and treatment* (pp. 15-29). New York, NY: Guildford Press.

Luxenberg, T., Spinazzola, J., Hildalgo, J., Hunt, C., & van der Kolk, B. A. (2001). Complex trauma and disorders of extreme stress (DESNOS), Part II: Treatment. *Directions in Psychiatry, 21,* 395-414.

Luxenberg, T., Spinazzola, J., & Van der Kolk, B. A. (2001). Complex trauma and disorders of extreme stress (DESNOS), Part I: Assessment. *Directions in Psychiatry, 21,* 363-392.

Lynn, S. J., Rhue, J. W., & Green, J. P. (1988). Multiple personality and fantasy proneness: Is there an association or dissociation. *British Journal of Experimental and Clinical Hypnosis*, 5, 138-142.

Macnaughton, I. (2004). *Body, breath, and consciousness: A somatic anthology.* Berkeley, CA: North Atlantic Press.

Mai, F. M. (1995). Psychiatrists' attitudes to multiple personality disorder: A questionnaire study. *Canadian Journal of Psychiatry, 40*, 154-157.

Main, M. (1999). Epilogue. Attachment theory: Eighteen points with suggestions for future studies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: theory, research, and clinical applications* (pp. 845-887). New York, NY: Guilford Press.

Main, M. (2002). An introduction to attachment theory. In *Attachment: From Early Childhood Through The Lifespan* (tape 2 of 10). Los Angeles, CA: Lifespan Institute of Learning.

Main, M. (2003, November, 15). Clinical applications of attachment theory: The work of Mary Main and Erik Hesse. Paper presented at the San Gabriel Psychological Association, Pasadena, CA.

Main, M., & Hess, E. (1990). Parent's unresolved traumatic experiences are related to infant disorganized attachment status: Is frightening and/or frightening parental behavior the linking mechanism? In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years* (pp. 161-182). Chicago, Il: University of Chicago Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.), *Growing points of attachment theory and research. Monographs of the Society for Research in Child Development, 50*(1-2), Serial No. 209, 66-104.

Main, M., & Solomon, J. (1986). Discovery of an insecure disorganized/disoriented attachment pattern: Procedures, findings and implication for classification of behavior. In M. W. Yogman & T. B. Brazelton (Eds.), *Affective development in infancy* (pp. 95-124). Norwood, NJ: Ablex.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during Ainsworth Strange Situation. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years* (pp. 121-160). Chicago, IL: University of Chicago Press.

Marcum, J. M., Wright, K., & Bissell, W. G. (1986). Chance discovery of multiple personality disorder in a depressed patient by amobarbital interview. *Journal of Nervous and Mental Disorders, 174*, 489-492.

Marmar, C. R., Weiss, D. S., Schlenger, W. E., Fairbanks, J. A., Jordan, K., Kulka, R. A., & Hough, R. L. (1994). Peritraumatic dissociation and posttraumatic stress in male Vietnam theatre veterans. *American Journal of Psychiatry, 151,* 902-907.

Migdow, J. (2003). The problem with pleasure. *Journal of Trauma and Dissociation, 4*, 5-25.

Miller, A. (1981). *Prisoners of childhood.* New York: Basic Books.

Mitchell, S. A. (1973). Foreword. In J. Bowlby, *Attachment and loss, Vol. 2: Separation, anxiety and anger* (pp. vii-x). New York, NY: Basic Books.

Munthe, A. (1929). *The story of San Michele*. London, England: John Murray.

Myers, C. S. (1940). *Shell shock in France* 1914-18. Cambridge, England: Cambridge University Press.

National Child Abuse and Neglect Data System (NCANDS). (2011). *Data on health and well-being of American Indians, Alaska Natives and other Native Americans data catalog*. Retrieved from http://aspe.hhs.gov/hsp/06/catalog-ai-an-na/NCANDS.htm

Nijenhuis, E. R. S. (2004). *Somatoform dissociation: Phenomena, measurement, and theoretical issues*. New York, NY: Norton.

Nemiah, J. C. (1991). Dissociation, conversion, and somatization. In A. Tasman & T. A. Goldfinger (Eds.), *American psychiatric press review of psychiatry* (Vol. 10, pp. 248-260). Washington, DC: American Psychiatric Press.

Ogden, Pat. (2004). *Integrating cognitive and somatic approaches in the treatment of trauma*. Paper presented at the Lifespan Learning Conference. Los Angeles, CA: Lifespan Learning Institute.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body*. New York, N.Y: Norton.

Olio, K., & Cornell, W. (1993). The therapeutic relationship as the foundation for treatment of adult survivors of sexual abuse. *Psychotherapy, 30*, 512-523.

Ormrod, R. K., & Finkelhor, D. (2005). Using new crime statistics to understand crimes against children—child pornography, juvenile prostitution, and hate crimes against youth. In K. A. Kendall-Tackett & S. M. Giacomoni (Eds.), *Child victimization* (pp. 1-30). Kingston, NJ: Civic Research Institute.

Pain, C., Bluhm, R. L., & Lanius, R. A. (2009). Dissociation in patients with chronic PTSD: Hyperactivation and hypoactivation patterns, clinical and neuroimaging perspective. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 373-402). New York, NY: Routledge.

Panksepp, J. (1998). Energy is delight: The pleasures and pain of brain regulation systems. In *Affective neuroscience: The foundation of human and animal emotions* (pp. 164-186). New York, NY: Oxford University Press.

Pastor, D. (1981). The quality of mother-infant attachment and its relationship to toddler's initial sociability with peers. *Developmental Psychology, 17*, 326-335.

Pearlman, L. A., & Saakvitne, K. W. (1995). In *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York, NY: Norton.

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and "use dependent" development of the brain: How states become "traits." *Infant Mental Health Journal, 151*, 732-737.

Pines, M. (1978). Invisible playmates. *Psychology Today, 12*, 28-38.

Prince, M. (1906). *The dissociation of a personality.* New York, NY: Longmans, Green. Reprint: New York, NY: Greenwood Press.

Prince, M. (1909). The psychological principles and field of psychotherapy. *Journal of Abnormal Psychology, 1*, 170-187.

Putnam, F. W. (1985). Dissociation as a response to extreme trauma. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 65-97). Washington, DC: American Psychiatric Press.

Putnam, F. W. (1989*). Multiple personality disorder.* New York, NY: Guilford Press.

Putnam, F. W. (1991). Dissociative phenomena. In A. Tasman & S. M. Goldfinger (Eds.), *American psychiatric press review of psychiatry* (Vol. 10, pp. 145-160). Washington, DC: American Psychiatric Press.

Putnam, F. W. (1998, January). Why is it so difficult for the epidemic of child abuse to be taken seriously? David L. Chadwick endowed lecture presented at the *Conference on Responding to Child Maltreatment*, San Diego, CA.

Putnam, F. W., Guroff, J. J., Silberman, E. K., Barban, L., & Post, R. M. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry, 47*, 285-293.

Raucher, H. (Writer), & Mulligan, R. (Director). (1971). *Summer of '42* [Motion picture]. USA: Warner Brothers.

Resch, F. (2004). Entwicklungs psychopathology and strulcturdynamik. [Psychopathology of development and structural dynamics.] *Fortschritte der Neurologie und Psychiatrie, 72*, S23-S28.

Robertson, J., & Bowlby, J. (1952). Responses of young children to separation from their mothers. *Courr. Cent. Int. Enf. 2*, 131-42.

Roddenberry, G. (Producer). (1966-1969). *Star Trek* [Television series]. Los Angeles, CA: Paramount Television.

Rodriguez-Srednicki, O. & Twaite, J. A. (2006). Assessment of adult survivors of childhood abuse. In *Understanding, assessing, and treating adult victims of childhood abuse* (pp. 235-259). New York, NY: Jason Aronson.

Rosenbaum, M. (1980). The role of the term schizophrenia in the decline of the diagnosis of multiple personality. *Archives of General Psychiatry, 37*, 1383-1385.

Rosenberg, J., Rand, M. L., & Assay, D. (1989*). Body, self, and soul: Sustaining integration.* Atlanta, GA: Humanics.

Ross, C. A. (1997). *Dissociative identity disorder. Diagnosis, clinical features, and treatment of multiple personality* (2nd ed.). New York, NY: Wiley.

Ross, C. A. (2000). *The trauma model: A solution to the problem of comorbidity in psychiatry.* Richardson, TX: Manitou Communications.

Ross, C. A. (2009). Expert commentary: How the dissociative structural model integrates DID and PTSD, plus a wide range of comorbidity. International Society for the Study of Trauma and Dissociation. *Members Clinical Corner,* April, 1-6.

Ross, C., & Norton, G. (1988). Multiple personality disorder patients with a prior diagnosis of schizophrenia. *Dissociation, 1*(2), 39-42.

Rothschild B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment.* New York, NY: Norton.

Sanders, B., & Giolas, M. H. (1991). Dissociation and childhood trauma in psychologically disturbed adolescents. *American Journal of Psychiatry, 148*, 50-54.

Sapp, M. (2000). Phenomena of hypnosis: APA'S division 30 definition of hypnosis. In *Hypnosis, dissociation, and absorption: Theories, assessment, and treatment (30)* (pp. 19-54). Springfield, IL: Charles C. Thomas.

Sar, V. (2008). President's column: Where are we in medicine and psychiatry? *International Society for the Study of Trauma and Dissociation Newsletter, 26*(2), 1-5.

Scaer, R. C. (2001). The neurophysiology of dissociation and chronic disease. *Applied Psychophysiology and Biofeedback, 26*(91), 73-91.

Scaer, R. C. (2005). *The trauma spectrum: Hidden wounds and human resiliency.* New York, NY: Norton.

Scharff. D. E. (1982). *The sexual relationship.* Boston, MA: Routledge & Kegan Paul.

Schore, A. N. (1982). Foreword. In J. Bowlby, *Attachment and Loss, Vol. 1: Attachment* (pp. xi-xxii). New York, NY: Basic Books. (Original work published 1969)

Schore, A. N. (1994). *Affect regulation and the origin of the self*: Hillsdale, NJ: Lawrence Erlbaum.

Schore, A. N. (2001).The right brain as the neurobiological substratum of Freud's dynamic unconscious. In D. Scharff & J. Scharff (Eds.), *Freud at the millennium: The evolution and application of psychoanalysis* (pp. 61-88). New York, NY: Other Press.

Schore, A. N. (2003). *Affect regulation and the repair of the self.* New York, NY: Norton.

Schore, A. N. (2009). Attachment trauma and the developing right brain: Origins of pathological dissociation. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 107-141). New York, NY: Routledge.

Schultz, R., Braun, B. G., & Kluft, R. P. (1989). Multiple personality disorder phenomenology of selected variables in comparison to major depression. *Dissociation, 2*(1), 245-51.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing (EMDR), Basic principles protocol, and procedures.* New York, NY: Guildford Press.

Sedlak, A. J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Li, S. (2010). *Fourth national incidence study of child abuse and neglect (NIS-4): Report to congress executive summary.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Shengold, L. (1979). Child abuse and deprivation: Soul murder. *Journal of the American Psychoanalytic Association, 27*, 533-559.

Shengold, L. (1989). *Soul murder: The effects of childhood abuse and deprivation.* New York, NY: Fawcett Columbine.

Shengold, L. (1999). *Soul murder revisited.* New Haven, CT: Yale University Press.

Shusta-Hochberg, S. R. (2004). Therapeutic hazards of treating child alters as real children in dissociative identity disorder. *Journal of Trauma & Dissociation, 5*(1), 13-27.

Siegel, D. J. (1999). *The developing mind.* New York, NY: Guildford Press.

Siegel, D. J. (2007). *The mindful brain: Reflection and attunement in the cultivation of wellbeing.* New York, NY; Norton.

Silberg, J. L. & Dallam, S. (2009). Dissociation in children and adolescents: At the crossroads. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 67-81). New York, NY: Routledge.

Slade, A. (1999). Attachment theory and research: Implications for the theory and practice of individual psychotherapy with adults. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications,* (pp. 575-594). New York, NY: Guilford Press.

Smith, E. (1985). *The body in psychotherapy.* Jefferson, NC: McFarland.

Sokolov, E., Spinks, J., Naatanen, R., & Heikki, L. (2002). *The orienting response in K.* Mahwah, NJ: Erlbaum.

Solomon, J., & George, C. (1996). Defining the caregiving system: Toward a theory of caregiving. *Infant Mental Health Journal, 17,* 183-197.

Solomon, J. & George, C. (1999). The measurement of attachment security in infancy and childhood. In J. Cassidy and P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical application* (pp. 287-316). New York, NY: Guilford Press.

Spanos, N. P. (1996). *Multiple identities and false memories: A sociocognitive perspective.* Washington, DC: American Psychological Association.

Spanos, N. P., Weekes, J. R., & Bertrand, L. D. (1985). Multiple personality: A social psychological perspective. *Journal of Abnormal Psychology, 94,* 362-376.

Spiegel, D. (1989). Hypnosis in the treatment of victims of sexual abuse. *Psychiatric Clinics of North America, 12*(2), 295-305.

Spiegel, D. (1991). Dissociation and trauma. In A. Tasman & S. M. Goldfinger (Eds.), *American psychiatric press review of psychiatry* (Vol. 10, pp. 261-275). Washington, DC: American Psychiatric Press.

Spiegel, D., & Cardena, E. (1991). Disintegrated experience: The dissociative disorders revisited. *Journal of Abnormal Psychology, 100,* 366-378.

Spiegel, H. (1963). The dissociation-association continuum. *Journal of Nervous and Mental Disease, 136,* 374-378.

Spira, J. L. (1996). Introduction: Understanding and treating dissociative identity disorder. In *Treating dissociative identity disorder* (pp. xvii-iv). San Francisco, CA: Jossey–Bass.

Sroufe, L. A. (1983). Infant-caregiver attachment and patterns of adaptation in preschool: The roots of maladaptation and competence. In M. Perlmutter (Ed.), *The Minnesota symposia on child psychology: Vol. 16. Development and policy concerning children with special needs* (pp. 41-83). Hillsdale, NJ: Erlbaum.

Sroufe, L. A., Bennett, C., Englund, M., Urban, J., & Shulman, S. (1993). The significance of gender boundaries in preadolescence: Contemporary correlates and antecedents of boundary violation and maintenance. *Child Development, 64*, 455-466.

Sroufe, L. A., & Waters, E. (1977). Attachment as an organizational construct. *Child Development, 48*, 1184-1199.

Stamm, B. H. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Lutherville, MD: Sidran Press.

Steel, B. (1986). Child abuse. In A. Rothstein (Ed.). *The reconstruction of trauma* (pp. 59-72). Madison, CT: International Universities Press.

Steele, K., van der Hart, O., & Nijenhuis, E. (2005). Phase-oriented treatment of structural dissociation in complex traumatization: Overcoming trauma-related phobias. *Journal of Trauma and Dissociation, 6*(3), 11-53.

Steele, K., van der Hart, O., Nijenhuis, E. (2009). The theory of trauma-related structural dissociation of the personality. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders* (pp. 239-258). New York, NY: Routledge.

Steinberg, M. (1994a). *Interviewer's guide to the structured clinical interview for DSM-IV dissociative disorders revised.* Washington, DC: American Psychiatric Press.

Steinberg, M. (1994b). *Structured clinical interview for DSM-IV dissociative disorders-revised (SCID-D-R)* (2nd ed.). Washington, DC: American Psychiatric Press.

Steinberg, M. (1995). *Handbook for the assessment of dissociation: A clinical guide.* Washington, DC: American Psychiatric Press.

Steinberg, M., Rounsaville, B., & Chiccetti, D. V. (1990). A structured clinical interview for DSM-III-R dissociative disorders: Preliminary report on a new diagnostic instrument. *American Journal of Psychiatry*, 147, 76-82.

Steinberg, M., & Schnall, M. (2000). *The stranger in the mirror: Dissociation-the hidden epidemic*. New York, NY: HarperCollins.

Stern, D. L. (1980). Foreword. In J. Bowlby, *Loss: Sadness and depression* (pp. xiii-xiv). New York, NY: Basic Books.

Stern, D.N. (1985). *The interpersonal world of the infant*. New York, NY: Basic Books.

Stern, D.N. (2004). *The present moment in psychotherapy and everyday life*. New York, NY: Norton.

Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148*,10-20.

Truijillo, K., Lewis, B. O., Yeager, C. A., & Gidlow, B. (1996). Imaginary companions of school boys and boys with dissociative identity disorder/multiple personality disorder: A normal to pathologic continuum. *Child and Adolescent Psychiatric Clinics of North America, 5*, 375-391.

Twombly, Joanne, H. (2000). Incorporating EMDR and EMDR adaptations into the treatment of clients with dissociative identity disorder. *Journal of Trauma & Dissociation, 1*(2), 61-81.

van der Hart, O., & Dorhay. M. J. (2009). History of the concept of dissociation. In P. Dell & J. A. O'Neil. (Eds.). *Dissociation and the dissociative disorders* (3-26). New York, NY: Routledge.

van der Hart, O,, & Friedman, B. (1989). Readers guide to Pierre Janet: A neglected intellectual heritage. *Dissociation, 2*(1), 3-16.

van der Hart, O., & Horst, R. (1989). The dissociation theory of Pierre Janet. *Journal of Traumatic Stress*, 2, 397-412.

van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2005). Dissociation: An insufficiently recognized major feature of complex posttraumatic stress disorder. *Journal of Traumatic Stress, 18,* 413-424.

van der Hart, O., Nijenhuis, E., & Steele, K.. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization.* New York, NY: Norton.

van der Hart, O., & Steele, K. (2000). Critical issues column. *International Society for the Study of Dissociation News, 18*(2), 4-5.

van der Hart, O., Steele, K., Boon, S., & Brown, P. (1993). The treatment of traumatic memories: Synthesis, realization, and integration. *Dissociation, 2*(6), 162-180.

Van der Kolk, B. A. (1994). Forward. In J. P. Wilson & J. D. Lindy (Eds.), *Countertransference in the treatment of PTSD* (pp. vii-xii). New York, NY: Guilford Press.

van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (1996). Trauma and memory. In *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 279-303). New York, NY: Guilford Press.

van der Kolk, B. A., & van der Hart, O. (1991). The intrusive past: The flexibility of memory and the engraving of trauma. *American Imago, 48*, 425-454.

van der Kolk, B. A., van der Hart, O., & Marmar, C. R. (1996). Dissociation and information processing in posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 303-327). New York, NY: Guilford Press.

van Ijzendoorn, M. H., & Sagi, A. (1999). Cross-cultural patterns of attachment: Universal and contextual dimensions. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 713-734). New York, NY: Guilford Press.

Waterman, J., & Lusk, R. (1986). Scope of the problem. In *Sexual abuse of young children* (pp. 3-12). New York, NY: Guilford Press.

Watkins, H., & Watkins, J. G. (1993). Ego-state therapy in the treatment of dissociative disorders. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality* (pp. 277-299). Washington, DC: American Psychiatric Press.

Weinfield, N. S., Sroufe, A., Egeland, B., & Carlson, E. A. (1999). The nature of individual differences in infant-caregiving attachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 68-88). New York, NY: Guilford Press.

West, L. J. (1967). Dissociative reaction. In A. M. Freeman & H. I. Kaplan (Eds.), *Comprehensive textbook of psychiatry* (pp. 885-899). Baltimore, MD: Williams & Wilkins.

Wieland, Sandra. (2011). Dissociation in children and adolescents. In *Dissociation in traumatized children and adolescents* (pp. 1-27). New York, NY: Routledge.

Wilbur, C. B. (1984). Multiple personality and child abuse. *Psychiatric Clinics of North America, 7*(1), 3-7.

Williams, T. L., Loewenstein, R. J., & Gleaves, D. H. (2004). *Exploring assumptions about DID: An investigation of suggestibility, hypnotizability, fantasy proneness, and personality variables.* Paper presented at the 20th Annual Meeting for the International Society for the Study of Dissociation. New Orleans, LA.

Wilson, J. P., & Lindy, J. D. (1994). *Countertransference in the treatment of PTSD.* New York, NY: Guilford Press.

Wilson, J. P., & Thomas, R. B. (2004). *Empathy in the treatment of trauma and PTSD.* New York, NY: Brunner Routledge.

Wilson, S., & Barber, T. X. (1983). The fantasy-prone personality, implications for understanding imagery hypnosis, and parapsychological phenomena. In A. A. Sheikh (Ed.), *Imagery: Current theory, research and application* (pp. 340-390). New York, NY: Wiley.

Winfield, N., Sroufe, L. A., Egeland, B., & Carlson, E. A. (1999). In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 8-88). New York, NY: Guilford Press.

Winnicott, D. W. (1960). Ego distortion in terms of true and false self. In *The maturational process and the facilitating environment* (pp. 158-165). Madison, CT: International Universities Press.

Winnicott, D.W. (1965). Primitive emotional development. *International Journal of Psychoanalysis, 26*, 137-143.

Wolfe, V. V. (2007). Child sexual abuse. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (pp. 647-726). New York, NY: Guilford Press.

Woody, E. Z., & Bowers, K. S. (1994). A frontal assault on dissociated control. In S. J. Lynn & J. W. Rhue (Eds.), *Dissociation: Clinical, theoretical and research perspectives* (pp. 52-79). New York, NY: Guilford Press.

Yeager, C., & Lewis, D. (1996). The intergenerational transmission of violence and dissociation. *Child and Adolescent Psychiatric Clinics of North America, 5*, 293-430.

Young, W. C. (1988a). Observations of fantasy in the formation of multiple personality disorder. *Dissociation, 1*(3), 13-19.

Young, W. C. (1988b). Psychodynamics and dissociation: All that switches is not split. *Dissociation, 1*(1), 33-38.

Zanarini, M. C., & Jager-Hyman, S. (2009). Dissociation in borderline personality disorder. In P. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders*, (pp. 487-493). New York, NY: Routledge.

Zeanah, C. H., Mammen, O., & Lieberman, A. (1993). Disorders of attachment. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (pp. 322-349). New York, NY: Guilford Press.

Zeig, J. K., & Rennick, P. J. (1991). Ericksonian hypnotherapy: A communicative approach to hypnosis. In S. J. Lynn & J. W. Rhue (Eds.), *Theories of hypnosis: Current models and perspectives* (pp. 275-300). New York: Guilford Press.

ROSALIND M. MONAHAN Ph.D. 2011